Supreme Court, U.S.
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No. ———

IN THE
Supreme Court of the United States
OCTOBER TERM, 1994

NATIONAL POSTAL MAIL HANDLERS UNION,
A DIVISION OF LABORERS INTERNATIONAL UNION
OF NORTH AMERICA, AFL-CIO,
d/b/a MAIL HANDLERS BENEFIT PLAN,
Petitioner,

v.

MARILYN GOEPEL and RONALD GOEPEL,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Third Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether a civil action for breach of contract, which alleges that health insurance benefits provided a federal employee in a contract made pursuant to provisions of the Federal Employees Health Benefits Act, 5 U.S.C. § 8901, *et seq.*, between the United States Office of Personnel Management and the employee's health insurance plan carrier were wrongfully denied, is removable under 28 U.S.C. § 1441(b) as a "claim . . . arising under the . . . laws of the United States."

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PETITION FOR WRIT OF CERTIORARI

The National Postal Mail Handers Union, doing business as the Mail Handlers Benefit Plan, hereby petitions the Court for a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit in this case.[1]

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[1] Petitioner National Postal Mail Handlers Union is a division of the Laborers International Union of North America, AFL-CIO. Petitioner appears here in its capacity as the employee organization carrier and sponsor of the Mail Handlers Benefit Plan, a health benefits plan for federal government employees organized and operated under terms of the Federal Employees Health Benefits Act, 5 U.S.C. § 8901 *et seq.*

OPINIONS BELOW

The opinion of the court of appeals is reported at 36 F.3d 306 and is reprinted in the Appendix at App. 1a-22a. The district court's decision denying respondents' motion to remand is not officially reported. That decision is reprinted in the Appendix at App. 49a-57a.

JURISDICTION

The decision of the court of appeals was entered on September 27, 1994. The court of appeals denied petitioner's timely petition for rehearing on October 25, 1994. App. 44a-45a. This Court's jurisdiction is invoked pursuant to 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

Pertinent portions of the Federal Employees Health Benefits Act, 5 U.S.C. § 8901 *et seq.*, and of regulations issued thereunder by the United States Office of Personnel Management, are reprinted in the Appendix at App. 58a-63a. Pertinent portions of the federal question removal statute, 28 U.S.C. § 1441(b), are reprinted at App. 60a. Pertinent portions of the Federal Employees Health Benefits Act contract between the Office of Personnel Management and the National Postal Mail Handlers Union are reprinted at App. 64a-66a.

STATEMENT OF THE CASE

Respondents Ronald and Marilyn Goepel brought this action in New Jersey state court to challenge petitioner Mail Handlers Benefit Plan's denial of their claim for health benefits alleged to be due them under petitioner's Federal Employees Health Benefits Act ("FEHBA" or "Act") health plan contract. After petitioner had removed the case to the District Court for the District of New Jersey pursuant to 28 U.S.C. § 1441(b), and the district court had denied respondents' motion to remand, the district court granted summary judgment to petitioner. App. 23a-43a.

Without reaching the merits of that decision, the court below concluded that the case was not removable, vacated the judgment in petitioner's favor, and directed that the case be remanded to the New Jersey state court in which it originated. The court of appeals acknowledged that all of respondents' putative state law-based claims, including their FEHBA contract claim, might ultimately be determined to be preempted by the Federal Employees Health Benefits Act "and thus . . . governed by federal common law," App. 19a, but concluded that it need not reach the issue of whether state or federal law provided the rules of decision by which respondents' claims would be decided.[2] Specifically declining to decide that choice-of-law issue, the court of appeals held that, because the Federal Employees Health Benefits Act

> does not create a statutory cause of action vindicating the same interest that the Goepels' state causes of action seek to vindicate, namely the recovery of benefits from the Plan[,]

respondents' complaint did not fall within the federal question removal jurisdiction of the district court. App. 13a. The court of appeals recognized that its holding squarely conflicts with the Fourth Circuit's decision in *Caudill v. Blue Cross and Blue Shield of North Carolina*, 999 F.2d 74 (4th Cir. 1993), a case arising under the Federal Employees Health Benefits Act on facts virtually identical to those presented in this case.

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[2] On January 6, 1995, this Court granted a petition for writ of certiorari in *Rocky Mountain Hospital and Medical Service v. Phillips*, 63 U.S.L.W. 3513 (U.S. Jan. 6, 1995) (No. 94-555). The question presented in *Rocky Mountain Hospital and Medical Service* is whether federal question jurisdiction exists over claims, such as the one which gave rise to this litigation, seeking to recover benefits under a Federal Employees Health Benefits Act contract.

1. The Federal Employees Health Benefit Act

First enacted by Congress in 1959, the Federal Employees Health Benefits Act provides a comprehensive statutory scheme by which Congress has undertaken to provide health insurance coverage to some nine million federal employees and their families. In broad outline, the Act delegates to the Office of Personnel Management ("OPM")[3] the responsibility for contracting for the procurement of health insurance for those federal employees, and for administering the program of insurance which those contracts procure.

To carry out these responsibilities, OPM is authorized to enter into contracts with qualified insurance plan carriers, including employee organizations, under which those carriers offer health plan coverage to federal employees. 5 U.S.C. § 8902(a).[4] OPM has the specific responsibility to determine which benefits are "necessary or desirable" for inclusion in FEHBA benefit plans, and which "limitations and exclusions" should apply to those plans of benefits. *See* 5 U.S.C. § 8902(d), App. 58a. The benefit plan offerings OPM determines to be necessary, and the "maximums, limitations [and] exclusions" which OPM finds appropriate, are specified in the contracts which OPM makes with plan carriers. In order to assure that all such OPM contracts are uniformly administered and construed, Congress has specifically directed that the provisions of all such contracts

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[3] The United States Office of Personnel Management, successor to the United States Civil Service Commission, is "an independent establishment in the executive branch" of the federal government. 5 U.S.C. § 1101.

[4] OPM has contracted for more than 300 separate health benefit plans for federal employees pursuant to this program. Those plans are of two types: prepaid plans known as health maintenance organizations, or HMO's, and fee-for-service plans. Petitioner operates one of the largest fee-for-service plans in the FEHBA program, currently having enrolled more than 500,000 federal employees and their dependents.

> which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) *shall supersede and preempt any State or local law,* or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

5 U.S.C. § 8902(m)(1) (emphasis added) (App. 58a).[5]

In addition, OPM is responsible for determining what the premium charge will be for each of the plans for which it contracts. OPM's determination of the appropriate premium charge for each plan is governed by the statutory standard specified in 5 U.S.C. §§ 8902(i), 8906. Payments of these premium charges, for which the employing federal agencies and the individual federal employees who enroll in the plans are jointly responsible, are made from an account established in the Treasury of the United States for this purpose. 5 U.S.C. § 8909. The Act provides all federal employees with the option to choose from among a large number of available plans, offering differing benefit structures and different rates. All federal employees are guaranteed the right to participate in a FEHBA plan—and to change enrollment from one plan to another—without regard to any preexisting condition. *See* 5 U.S.C. § 8905(e). Employees desiring to participate in a FEHBA plan do so by "enrolling" in the plan of their choice at the federal agency where they are employed. 5 C.F.R. § 890.301.

FEHBA vests in OPM the statutory responsibility for ensuring that health services or supplies provided for in a FEHBA contract are actually provided to plan enrollees

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[5] The FEHBA preemption provision which now appears as 5 U.S.C. § 8902(m)(1) was added to the Act in 1978 for the "sole purpose [of] establish[ing] uniformity in benefits and coverage under the Federal employees' health benefits program." H.R. Rep. No. 282, 95th Cong., 1st Sess. 1 (1977). *See also,* to same effect, S. Rep. No. 903, 95th Cong., 2d Sess. 2 (1978).

in accordance with the terms of that contract. To this end, the statute directs OPM to insure that each contract into which OPM enters obligates the FEHBA plan "to pay for or provide a health service or supply" if OPM "finds that the employee . . . is entitled thereto under the terms of the contract." 5 U.S.C. § 8902(j), App. 58a.

OPM has implemented this provision of the statute, first, by including in every FEHBA contract specific language requiring the carrier to pay any claim OPM finds, upon review, to be required by that carrier's contract with OPM, App. 65a, and second, by promulgating regulations which provide enrollees dissatisfied with a plan's denial of a claim the opportunity to obtain OPM's administrative review of that denial. *See* 5 C.F.R. § 890.105, App. 60a-63a. Those OPM regulations also direct enrollees who wish to challenge OPM's decision on any such review to do so by bringing suit against the carrier. 5 C.F.R. § 890.107, App. 63a. Moreover, each insurance provider's contract with OPM specifies that no suit challenging a benefit claim denial may be brought until the enrollee has exhausted the OPM administrative review procedure, and further specifies that judicial review of any OPM decision affirming the denial of a contract benefit is governed exclusively by federal law, and is limited to review of the OPM decision to determine whether that decision was arbitrary or capricious. App. 66a.

As noted, petitioner Mail Handlers Benefit Plan offers one of the largest of the fee-for-service plans in the FEHBA program. Petitioner's contract with OPM for 1993 (the year in which this controversy arose) conformed in every respect with the statutory requirements governing the FEHBA program, and with the regulatory and programmatic requirements mandated by OPM in its supervisory capacity under the statute.

Since approximately 1981, respondent Ronald Goepel has been an enrollee in the Plan. Because he elected the Plan's family coverage option during that time, Ronald

Goepel's insurance covered his spouse, respondent Marilyn Goepel, as well. When in August, 1993, the Plan determined that its OPM contract statement of benefits did not provide coverage for a particular course of treatment sought by Marilyn Goepel, respondents initiated the litigation from which this petition ensues.

2. The Instant Litigation

Respondents commenced this action on August 19, 1993, in the Superior Court of New Jersey, Law Division, for Gloucester County, New Jersey. Their complaint stated four separate claims for relief, including a claim for breach of contract.[6] Respondents' breach of contract claim (stated in Count Two of their complaint) alleged that the Plan had "breached its contract by refusing to certify Marilyn Goepel to receive coverage" for the treatment she sought. Complaint, ¶¶ 24, 25. The complaint identified the contract petitioner allegedly breached as petitioner's "contractual statement of benefits for . . . covered persons," which had been "approved by the Office of Personnel Management ["OPM"] pursuant to the Federal Employees Health Benefit[s] Act . . ., 5 U.S.C. § 8901-8913 . . . ." Complaint, ¶¶ 5, 6.

Petitioner timely filed a notice of removal bringing the case to the United States District Court for the District of New Jersey. Petitioner asserted that removal was warranted because respondents' breach of contract claim sought relief under a procurement contract made by an agency of the federal government in furtherance of that agency's statutory responsibilities, thus stating a claim which arose under the laws of the United States within

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[6] In addition to the breach-of-contract claim, respondents' complaint set forth causes of action based on the New Jersey Law Against Discrimination (Count One), a New Jersey statute dealing with Unfair Trade Practice (Count Four), and a common law claim based upon alleged "Unconscionability" (Count Three). Neither of the common law claims—for breach of contract and for "unconscionability"—specified reliance on either state or federal law.

the meaning of 28 U.S.C. § 1441(b).[7] The district court denied respondents' motion to remand, rejecting their contention that their breach of contract claim "is merely a contractual dispute governed by state law." App. 49a. Instead, the district court reasoned that

> where the very legal framework by which federal employees receive health insurance is detailed by a federal statute, where there is an express exemption provision mandating uniformity of benefits (§ 8902 (m)(1)), where much of the cost of coverage is borne by the federal government, where the party contracting for the coverage is a government agency (OPM), and where there is an allowable administrative appeal of the denial of coverage, one can only be led to the conclusion that a dispute between a federal employee and his carrier is one arising under the laws of the United States.

App. 56a. Having determined that its jurisdiction had been properly invoked, the district court granted petitioner's motion for summary judgment, and respondents appealed.

3. The Decision of the Court of Appeals

The court of appeals considered only the issue of whether the district court "had federal question removal jurisdiction over the Goepels' claims . . . ." App. 5a. The court's analysis of this issue began with the observation that respondents' complaint "does not purport to rely on federal law [and does not evidence] any indication that the Goepels intended to invoke federal common law" to provide the right to relief on their breach-of-contract claim. App. 6a. The court recognized that federal common law might, in fact (as petitioner urged), provide respondents with a cause of action for breach of the

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[7] Petitioner invoked the pendent jurisdiction provisions of 28 U.S.C. § 1443 to support removal of Counts One, Three, and Four of respondents' complaint.

FEHBA contract, App. 6a, fn. 3, but believed that possibility to be immaterial to its resolution of the federal question removal jurisdiction issue.[8] Instead, finding no explicit invocation of federal law on the face of respondents' complaint, the court examined whether federal question removal jurisdiction existed notwithstanding the absence of such explicit reliance.

The court answered this question in the negative. Rejecting petitioner's argument that respondents' complaint is "really one of federal law" because the contract under which they claimed is a federal procurement contract, the court held that a claim is "completely preempted," and thus removable, only if

> the statute relied upon by the defendant as preemptive contains civil enforcement provisions within the scope of which the plaintiff's state claim falls[,] *Railway Labor* [*Executives Ass'n v. Pittsburgh & Lake Erie R. Co.*], 858 F.2d [936] at 942 (citing *Franchise Tax Bd.* [*of State of Cal. v. Construction Laborers Vacation Trust for Southern Cal.*], 463 U.S. [1] at 24, 26[,]

and only if, in addition, the putatively preemptive federal statute provides

> a clear indication of a Congressional intent to permit removal despite the plaintiff's exclusive reliance on state law.

App. 10a. This "two-part test for complete preemption" is, in the view of the court of appeals, "the only basis for recharacterizing a state law claim as a federal claim removable to a district court." App. 11a. Because the court did not find in FEHBA

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[8] The court below recognized that the contract under which respondents claimed is a "federal contract," but concluded that respondents' complaint did not " 'raise a federal question on its face' merely by virtue of the fact that it alludes to a federal contract." App. 7a.

> a cause of action vindicating a beneficiary's interest in recovering his or her benefits under a plan[,]

the court concluded that a claim for breach of a FEHBA health benefits contract is not removable from state to federal court. App. 12a-13a.[9]

The court recognized that its decision on this issue conflicts with the decision of the Fourth Circuit in *Caudill v. Blue Cross and Blue Shield of North Carolina*, 999 F.2d 74 (4th Cir. 1993), but believed that its own prior decisions developing the "two-part test for complete preemption" required the court

> to reject the *Caudill* court's holding that *Boyle* [*v. United Technologies Corp.*, 487 U.S. 500 (1988)] authorizes the removal of a state law contract claim to recover benefits from a FEHBA plan.

App. 17a. The court acknowledged that the *Caudill* court, applying principles drawn from *Boyle*, had concluded that " '[i]n the area of federal employee health benefits, federal common law entirely replaces state contract law.' " App. 17a.[10] The court concluded, however, that the *Caudill* court's *Boyle* analysis is inapt in the FEHBA context. In the court's view, a FEHBA contract claim begun in state court is not "completely preempted," and thus is not removable to federal court, even if "federal common law entirely replaces state contract law" in the FEHBA area, as *Caudill* held, because FEHBA does not

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[9] In this connection, the court recognized the line of authority which holds that a FEHBA claimant must exhaust the OPM administrative review procedure before bringing suit on a denied claim. *See* p. 12, fn. 12, *infra*. In the court's view, however, even "mandatory OPM review would not constitute a statutory federal cause of action vindicating an insured's interest in recovering benefits under a FEHBA plan." App. 13a, fn. 10.

[10] As noted *supra*, at 3, fn. 2, in *Rocky Mountain Hospital and Medical Service v. Phillips*, this Court has agreed to review the question of whether FEHBA contract disputes arise under federal law within the meaning of 28 U.S.C. § 1331.

"contain[] an enforcement provision vindicating the" FEHBA contract claim. App. 18a.

REASONS FOR GRANTING THE PETITION

The decision of the court below places that court directly in conflict with the Fourth Circuit, as evidenced by *Caudill*, on a question of considerable significance to the administration of the Federal Employees Health Benefits program. Moreover, the court's strict application in this case of the "complete preemption" formulation developed in its decisions in *Railway Labor* and *Allstate Ins. Co. v. 65 Security Plan*, 897 F.2d 90 (3d Cir. 1989), results in the rejection of federal question removal for a category of claims—those in which a cause of action is created by federal common law—over which original federal question jurisdiction is conferred by 28 U.S.C. § 1331. The court of appeals thus perpetuates its conflict with the Eighth Circuit on this issue, *see Deford v. Soo Line R. Co.*, 867 F.2d 1080 (8th Cir.), *cert. denied*, 429 U.S. 927 (1989), a conflict which illustrates lingering uncertainty among the circuit courts of appeals regarding the proper construction of the federal question removal statute, 28 U.S.C. § 1441(b). Resolution of these important issues of federal question jurisdiction warrants this Court's review of the decision below.

1. In *Caudill*, the Fourth Circuit affirmed the removal under 28 U.S.C. § 1441(b) of a civil action which sought to enforce contract rights allegedly due a federal government employee under a Federal Employees Health Benefits Act contract. The court below, confronted with a virtually identical claim seeking to enforce rights under a similar Federal Employees Health Benefits Act contract, held that no federal question removal jurisdiction existed over that claim.[11] The court's opinion demonstrates that

[11] *Caudill* involved a claim for benefits asserted by an enrollee in the government-wide service benefit plan operated by the Blue

its decision on the removal jurisdiction issue would not change even if it were to agree with the *Caudill* court that "[i]n the area of federal employee health benefits, federal common law entirely replaces state contract law." *Caudill*, 999 F.2d at 79. In the Third Circuit, therefore, FEHBA plan enrollees may litigate their Federal Employees Health Benefits Act contract claims in state courts even if all aspects of those claims are created and governed by federal law.[12]

The conflict between the holding of the court below and that of the Fourth Circuit in *Caudill* thus centers not on proper construction of the Federal Employees Health

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Cross/Blue Shield Association under contract with the Office of Personnel Management. Like respondents in this case, the plan enrollees in *Caudill* sought and were denied plan precertification of eligibility for a specified course of treatment for breast cancer. *Caudill*, 999 F.2d at 76.

[12] In addition to the Fourth Circuit (in *Caudill*), the Courts of Appeals for the Fifth, Seventh, Eighth, Ninth, and Eleventh Circuits have all concluded that FEHBA contract claim disputes arise under and are governed by federal law. *See Burkey v. Government Employees Hosp. Ass'n*, 983 F.2d 656 (5th Cir. 1993); *Harris v. Mutual of Omaha Companies*, 992 F.2d 706 (7th Cir. 1993); *Nesseim v. Mail Handlers Ben. Plan*, 995 F.2d 804 (8th Cir. 1993); *Hayes v. Prudential Ins. Co. of America*, 819 F.2d 921 (9th Cir. 1987), *cert. denied*, 484 U.S. 1060 (1988); *Tackitt v. Prudential Ins. Co.*, 758 F.2d 1572 (11th Cir. 1985). *See also Kobleur v. Group Hospitalization and Medical Services, Inc.*, 954 F.2d 705 (11th Cir. 1992) (applying federal administrative law principles to conclude that exhaustion of OPM review procedure is required before suit may be brought on disputed FEHBA claim); *Kennedy v. Empire Blue Cross and Blue Shield*, 989 F.2d 588 (2d Cir. 1993) (same).

In *Howard v. Group Hosp. Service*, 739 F.2d 1508 (10th Cir. 1984), the Court of Appeals for the Tenth Circuit held that a FEHBA contract claim dispute did not fall within the district court's federal question jurisdiction, and thus was not removable under 28 U.S.C. § 1441(b). The Tenth Circuit followed *Howard* in *Rocky Mountain Hospital and Medical Service v. Phillips*, No. 93-1456 (10th Cir., June 30, 1994), *cert. granted*, 63 U.S.L.W. 3513 (No. 94-555, Jan. 6, 1995).

Benefits Act, but on proper construction of the federal question removal statute, 28 U.S.C. § 1441(b). Adhering to the principle that the

> test for determining the existence of federal question jurisdiction under the removal statute is identical to the jurisdictional test of 28 U.S.C. § 1331[,]

Caudill, 999 F.2d at 77, the *Caudill* court examined the FEHBA claim before it, under the standards set forth in *Boyle v. United Technologies Corp.,* 487 U.S. 500 (1988), to determine whether that claim arose under federal common law. *Caudill,* 999 F.2d at 77. That inquiry required, first, a determination of whether a claim of rights under a federally-negotiated FEHBA health benefits procurement contract implicates

> a uniquely federal interest so important that the "federal common law" supplants state law either partially or entirely regardless of Congress' intent to preempt the area involved.

Id. If FEHBA claim disputes do, in fact, implicate important federal interests, the court must then inquire whether those federal interests would be jeopardized by the application of conflicting state law.[13] In the *Caudill* court's view, both branches of this test are met in the FEHBA context.

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[13] This case provides an instructive example of the threat to FEHBA uniformity which application of state law would represent. Respondents argued in the district court that the FEHBA contract under which they claimed should be construed under the so-called "reasonable expectations" rule fashioned by New Jersey courts. That concept, however, has not been embraced by all the states. *See, e.g., Park-Ohio Industries, Inc. v. The Home Indem. Co.,* 975 F.2d 1215 (6th Cir. 1992) (Ohio courts have rejected "reasonable expectations" doctrine); *Nelson v. Becton,* 929 F.2d 1287, 1290-91 (8th Cir. 1991) (federal common law does not recognize "reasonable expectations" doctrine which has been adopted in the courts of 12 states). Thus, if state law were applied as respondents urged, identical FEHBA claim disputes could be decided differently in, for example, New Jersey and Ohio.

The court found that the first of these requirements is satisfied in the FEHBA area because

> imposition of state law liability [on a FEHBA plan carrier] would seriously damage not only the government's ability to enter into contracts with health insurers, but also would affect the price paid for such contracts. Most importantly, the federal government is a party to this contract. Thus, a significant federal interest exists here . . . .

Caudill, 999 F.2d at 78. Regarding the second prong of the *Boyle* analysis, the *Caudill* court concluded that

> [a]pplication of state law to this federal contract would result in a patchwork quilt of benefits that varied from state to state under the same contract because of the vast differences in the common law of contracts from state to state. This situation would be fundamentally unfair to many federal employees . . . because enrollees in some states would pay higher premiums to cover services provided only to enrollees in other states. . . . Congress enacted a preemption provision [in FEHBA because] it was concerned about the possibility of state by state inconsistencies in health benefits to federal employees. . . . More importantly, allowing state courts to adjudicate these claims would also undercut the consistency Congress intended when it provided for the OPM review process.

Caudill, 999 F.2d at 79 (citations omitted). To the *Caudill*, court, therefore, the conclusion that

> federal jurisdiction existed over this claim and removal was proper

followed necessarily from the conclusion that

> [i]n the area of federal employee health benefits, federal common law entirely replaces state contract law.

Id.[14]

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[14] The proposition that 28 U.S.C. § 1331 creates jurisdiction in the district courts to hear claims founded on federal common law

Unlike the *Caudill* court, the court below believed it unnecessary to determine whether "federal common law entirely replaces state contract law" in the FEHBA area.

> We need not reach the question of whether the Goepels' state law claims are preempted by FEHBA, *and thus are governed by federal common law.*

App. 19a (emphasis supplied). *See also* App. 6a, fn. 3 ("We do not reach the question of whether the Goepels could have stated a cause of action under federal common law"). In the court's view, respondents' contract claim was not removable because even if every aspect of that claim were ultimately to be governed by federal common law, the claim was nonetheless not "completely preempted."

The court below apparently believed this conclusion to be compelled by this Court's decisions in *Franchise Tax Bd. of State of Cal.* v. *Construction Laborers Vacation Trust for Southern California*, 463 U.S. 1 (1983), and *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987). As the court explained,

> [b]ased on th[e] distinction between Franchise Tax Bd., on the one hand, and Avco and Metropolitan, on the other hand, we have held that the complete preemption doctrine applies only if "the statute relied upon by the defendant as preemptive contains civil enforcement provisions within the scope of which the

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is well established. *National Farmers Union Ins. Companies v. Crow Tribe of Indians*, 471 U.S. 845, 850 (1985) ("It is well settled that this statutory grant of 'jurisdiction will support claims founded upon federal common law as well as those of a statutory origin.' Federal common law as articulated in rules that are fashioned by court decisions are 'laws' as that term is used in § 1331. Thus, in order to invoke a federal district court's jurisdiction under § 1331, it was not essential that the petitioners base their claim on a federal statute or a provision of the Constitution."); *Illinois v. City of Milwaukee*, 406 U.S. 91 (1972) (footnotes omitted).

> plaintiff's state claim falls." Railway Labor, 858 F.2d at 942 (citing Franchise Tax Bd., 463 U.S. at 24, 26, 103 S.Ct. at 2854-55).

App. 10a. The conflicting applications of the federal question removal statute represented by these two decisions must be resolved by this Court if "the removal statutes and decisions of this Court are [] to have uniform nationwide application." *Grubbs v. General Elec. Credit Corp.*, 405 U.S. 699, 705 (1972).

2. The so-called "complete preemption" formulation which the court below believed precluded removal in this case is, as the court's opinion reflects, developed in its opinions in *Railway Labor Executives Ass'n v. Pittsburgh & Lake Erie R. Co.*, 858 F.2d 936 (3d Cir. 1988), and *Allstate Ins. Co. v. 65 Security Plan*, 879 F.2d at 90. As summarized in *Allstate Insurance*, 879 F.2d at 93,

> [t]he doctrine of complete preemption applies only when two circumstances are present: when the enforcement provisions of a federal statute create a federal cause of action vindicating the same interest that the plaintiff's cause of action seeks to vindicate and when there is affirmative evidence of a congressional intent to permit removal despite the plaintiff's exclusive reliance on state law.

In *Railway Labor Executives Ass'n*, the court concluded that the district court lacked subject matter jurisdiction over a state court-originated action seeking, in part, to recover

> accrued but unpaid wages, vacation pay, labor protection pay, life, health and insurance premiums, [and] pension plan premiums

allegedly owed to union-represented employees of the Pittsburgh & Lake Erie Railroad. 858 F.2d at 938. Subject matter jurisdiction failed, making removal improper, because the Railway Labor Act does not create a "cause

of action within the scope of which RLEA's state claim falls . . . ." 858 F.2d at 943. Similarly, in *Allstate Insurance*, the court concluded that a claim for indemnity or contribution made against an ERISA-governed employee welfare plan was not removable because ERISA's civil enforcement provisions, 29 U.S.C. § 1132(a), did not provide a cause of action "vindicating the same interest" that the insurer sought to vindicate. 879 F.2d at 93-94.

As the decision below demonstrates, the court's rigid application of these principles has the effect of injecting into the federal question removal analysis an element which is not required to establish original federal question jurisdiction, namely, the existence of an explicit federal statutory right of action.[15] What the court below characterizes as "complete preemption," as distinguished from "ordinary preemption," thus is not a preemption inquiry, but a jurisdictional inquiry.[16] This Court and the courts of appeals, including the court below, have affirmed that, under certain circumstances, the federal question

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[15] *Cf.* Alleva, "Prerogative Lost: The Trouble With Statutory Federal Question Doctrine After *Merrell Dow*," 52 Ohio St. L. J. 1477, 1568 (1991) ("Requiring the federal courts, in essence, to confirm their preliminary section 1331 determinations against specific statutory schemes effectively nullifies the general federal question statute . . . .").

[16] *See Bartholet v. Reishauer A.G. (Zurich)*, 953 F.2d 1073, 1075 (7th Cir. 1992): "Th[e] right to remove cases that 'really' depend on federal law goes by the misnomer 'complete preemption.' Preemption is what wipes out the state law, but the foundation for removal is the creation of federal law to replace state law. National law occupies the field; any claim within its domain then activates § 1441(b). The difficulty—what makes this subject a darling of judges but a bane of practice—is that national law never fully occupies a field." *See also Lister v. Stark*, 890 F.2d 941, 943, fn. 1 (7th Cir. 1989), *cert. denied*, 498 U.S. 1011 (1990) ("The use of the term 'complete preemption' is unfortunate, since the complete preemption doctrine is not a preemption doctrine but rather a federal jurisdiction doctrine.").

jurisdiction of the district courts created by 28 U.S.C. § 1331 will encompass causes of action which are not explicitly created in other federal statutes. *See, e.g., Illinois v. City of Milwaukee, Wis.*, 406 U.S. 91 (1972). Thus in *Deford v. Soo Line*, 867 F.2d 1080, the court affirmed the federal question removal of a claim substantially like the one presented in *Railway Labor Executives Ass'n*, on the ground that the Railway Labor Act evidenced

> preemptive force . . . so extraordinary that it takes over the whole field of railroad labor disputes arising from collective bargaining agreements.

Deford, 867 F.2d at 1085. The *Deford* court declined to follow the decision of the court below in *Railway Labor Executives Ass'n*, which the *Deford* court characterized as "unnecessarily narrow," giving rise to a conflict maintained by the decision in this case.[17] App. 18a, fn. 12.

The insistence of the court below that no federal question removal jurisdiction exists in the absence of an explicit federal statutory right of action also implicitly conflicts with that court's own recognition that original federal question jurisdiction need not always depend on the existence of an express federal statutory right of action. Thus the court held in *Northeast Dept. ILGWU Health and Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund*, 764 F.2d 147 (3d Cir. 1985), that federal question jurisdiction existed under 28 U.S.C. § 1331 over a claim for declaratory judgment to determine the relative rights and obligations of two ERISA-covered funds. The court found federal question jurisdiction to exist even though the action was not authorized by the specific enforcement provisions in ERISA § 502, 29 U.S.C. § 1132.

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[17] *Compare Smith v. Industrial Valley Title Ins. Co.*, 957 F.2d 90, 96 (3d Cir.), *cert. denied*, —— U.S. ——, 112 S. Ct. 3034 (1992) (Cowen, J., dissenting) ("The majority adopts a rigid rule that 'a private federal remedy for violating a federal statute is a prerequisite for finding federal question jurisdiction in this circumstance.' ").

Similarly, in *Airco Indus. Gases, Inc. Div. of BOC Group, Inc. v. Teamsters Health and Welfare Pension Fund of Philadelphia and Vicinity*, 850 F.2d 1028, 1034 (3d Cir. 1988), in which a contributing employer sought to recover overpayments allegedly made to an ERISA-covered benefit fund, the court held that jurisdiction existed under 28 U.S.C. § 1331 "to determine the existence of a federal common law cause of action based on unjust enrichment." As was the case in *Northeast Department, ILGWU*, the jurisdictional inquiry under 28 U.S.C. § 1331 was necessary because the ERISA enforcement provisions in 29 U.S.C. § 1132 clearly did not authorize the employer's action. *See also Plucinski v. I.A.M. Nat. Pension Fund*, 875 F.2d 1052, 1053, fn. 1 (3d Cir. 1989) (following *Airco Industrial Gases* holding that "there is federal jurisdiction over the federal common law cause of action that we recognize in this case"); *Luby v. Teamsters Health, Welfare, and Pension Trust Funds*, 944 F.2d 1176, 1186, fn. 10 (3d Cir. 1991) (same). Federal question jurisdiction over similar claims has been found in other courts of appeals as well. *See, e.g., Frank L. Ciminelli Const. Co., Inc. v. Buffalo Laborers Supplemental Unemployment Ben. Fund*, 976 F.2d 834 (2d Cir. 1992), and cases there collected; *Provident Life & Acc. Ins. Co. v. Waller*, 906 F.2d 985, 988 (4th Cir. 1990), *cert. denied*, 498 U.S. 982 (1990).

Nevertheless, under the "complete preemption" doctrine applied by the court below in this case, none of these federal common law cases would have been removable had they been initiated in state court. The "unnecessarily narrow" approach of the court below, *Deford*, 867 F.2d at 1086, thus makes federal question removal unavailable in such cases even though original federal question jurisdiction would have existed under 28 U.S.C. § 1331. That result subverts the interest of uniformity of construction of federal law for which federal question jurisdiction was created, *Merrell Dow Pharmaceuticals, Inc. v. Thompson*, 478 U.S. 804, 826 (1986) (Brennan,

J., dissenting), by impermissibly imposing a criterion for determining federal question *removal* jurisdiction which is not required to invoke original federal question jurisdiction. This Court's review of the decision below is thus required further to clarify, for courts and litigants alike, the proper boundaries of federal question removal jurisdiction.

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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January 23, 1995

APPENDICES

APPENDIX A

Filed September 27, 1994

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 93-5657

MARILYN GOEPEL; RONALD GOEPEL,
Appellants
v.
NATIONAL POSTAL MAIL HANDLERS UNION,
A DIVISION OF LIUNA, d/b/a
MAIL HANDLERS BENEFIT PLAN

On Appeal from the United States District Court
for the District of New Jersey
(D.C. Civ. No. 93-03711)

Argued August 2, 1994

BEFORE: STAPLETON and GREENBERG,
Circuit Judges, and ATKINS, *District Judge* *
(Filed: September 27, 1994)

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* Honorable C. Clyde Atkins, Senior United States District Judge for the Southern District of Florida sitting by designation.

OPINION OF THE COURT

GREENBERG, *Circuit Judge.*

I. FACTUAL AND PROCEDURAL HISTORY

A. *Factual History*

Appellant Ronald Goepel is a civilian employee of the United States Department of the Navy. He and his wife, appellant Marilyn Goepel, reside in Deptford, New Jersey, and have been enrolled in the Mail Handlers Benefit Plan, a fee-for-service health benefits plan, continuously since 1981. The Mail Handlers Benefit Plan is one of the health insurance plans available to federal government employees and their families. These healthcare plans are established pursuant to the Federal Employees Health Benefits Act (FEHBA), 5 U.S.C. § 8901 *et seq.*, which authorizes the Office of Personnel Management (OPM) to contract with carriers to provide health benefits plans to federal employees and their families.

OPM has contracted with the appellee, the National Postal Mail Handlers Union, a division of the Laborers International Union of North America, AFL-CIO, for the provision of the Mail Handlers Benefit Plan, and the Union has subcontracted with Continental Assurance Company to underwrite and administer the Plan. Each year OPM and the Union negotiate the terms of the Plan and document these terms in the Plan brochure, which is included as an appendix to the contract between OPM and the Union.

In January 1993, Marilyn Goepel learned that she had metastatic breast cancer. Thereafter, her consulting oncologist, Dr. David L. Topolsky of Hahnemann University, recommended that she undergo a treatment in which high doses of chemotherapy are followed by a peripheral

stem cell infusion (HDC/APCR).[1] On July 14, 1993, Dr. Topolsky wrote to the Plan requesting a determination of whether this treatment would be covered. Subsequently, on August 5, 1993, one of the Plan's customer service representatives stated in a telephone conversation that the treatment would not be covered, and indicated that it would take four to six weeks for Marilyn Goepel to receive an official notice of the Plan's denial of coverage in the mail.

The Goepels contacted Congressman Robert E. Andrews, who then sent a letter dated August 6, 1993, to OPM on their behalf. Within a week, OPM responded to Congressman Andrews' inquiry with a letter stating that page 19 of the 1993 Plan brochure "explicitly excludes benefits for HDCT/ABMT for breast cancer," and that therefore OPM had "no contractual basis to ask the Plan to provide benefits for Mrs. Goepel."[2] *See* app. at 445. The Plan also sent a letter dated August 10, 1993, to Dr. Topolsky, denying his request for pre-authorization of benefits for HDC/APCR for Mrs. Goepel on the grounds that the terms of the 1993 Plan brochure did not cover the use of HDC/APCR for the treatment of breast cancer. The Goepels did not appeal the Plan's denial of coverage

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[1] In a certification dated August 17, 1993, Dr. Topolsky explained the treatment as follows: it "works on the principal [sic] that the high doses of chemotherapy required to substantially kill or eradicate a patient's tumor will, as a side-effect, fatally destroy the patient's bone marrow. Therefore, a sample of either bone marrow or bone marrow cells which have been induced to enter the peripheral blood, are removed and stored in a freezer prior to the high-dose chemotherapy process. Following administration of the chemotherapy to the patient, the previously stored marrow cells are given back to the patient to protect them from an otherwise fatal toxic-side-effect of the treatment." *See* app. at 94.

[2] In its letter the OPM referred to the coverage sought as "high dosage chemotherapy/autologous bone marrow transplant (HDCT/ABMT)." In view of our result we need not discuss the significance, if any, of the distinction between HDC/APCR and HDCT/ABMT.

to OPM. However, the parties have stipulated that "[i]f plaintiffs were required to exhaust any right they had to seek review by OPM[,] . . . that exhaustion requirement was satisfied" by Congressman Andrews' letter to the OPM on Mrs. Goepel's behalf and OPM's response to that letter. *See* app. at 26.

B. *Procedural History*

On August 19, 1993, the Goepels filed a complaint in the Superior Court of New Jersey, Law Division, alleging that: (1) the Plan violated the New Jersey Law Against Discrimination, N.J. Stat. Ann. § 10:5-1 *et seq.* (West 1993); (2) the Plan breached its contract by refusing to certify her coverage for HDC/APCR; (3) any exclusion of coverage for HDC/APCR in the Plan brochure was unconscionable; and (4) the Plan's handling of Mrs. Goepel's claim involved unfair claim settlement practices in violation of N.J. Stat. Ann. § 17B:30-13.1 (West 1985). *See* app. at 1-10. On these bases, the Goepels sought a declaratory judgment, injunctive relief, damages, and counsel fees. *Id.*

The Plan immediately removed the case to the United States District Court for the District of New Jersey. In its notice of removal, the Plan stated that the case was removable pursuant to 28 U.S.C. §§ 1441(b) and (c), because the Goepels' breach of contract claim "arises under the laws of the United States," and their other state law claims were "inextricably intertwined" with the breach of contract claim. Subsequently, the Goepels filed a motion to remand the case to the state court on the grounds that their breach of contract claim did not raise a federal question, as it was merely a private contractual dispute between an insured and a health care insurer. However, the district court denied the motion to remand. *See Goepel v. Mail Handlers Benefit Plan*, No. 93-3711 (D.N.J. Sept. 10, 1993). Subsequently, the district court tried the case on the merits pursuant to a joint stipula-

tion of the facts, and entered judgment in favor of the Plan on all counts of the complaint. *See Goepel v. Mail Handlers Benefit Plan,* No. 93-3711 (D.N.J. Sept. 24, 1993).

II. DISCUSSION

In denying the Goepels' motion to remand this case to New Jersey Superior Court, the district court held that the case was removable pursuant to 28 U.S.C. § 1441(b) because "the matter [wa]s one 'arising under' the laws of the United States." *See Goepel v. Mail Handlers Benefit Plan,* No. 93-3711, at 2 (D.N.J. Sept. 10, 1993). Section 1441(b) provides in relevant part that

> [a]ny civil action of which the district courts have original jurisdiction founded on a claim or right arising under the Constitution, treaties or laws of the United States shall be removable without regard to the citizenship or residence of the parties.

The Goepels argue that the Plan improperly removed the case because they base their claims exclusively on state law, and thus do not raise any "federal questions" over which the district court would have original jurisdiction pursuant to 28 U.S.C. § 1331 and removal jurisdiction pursuant to 28 U.S.C. § 1441(b). We confine our review of the district court's subject matter jurisdiction to whether it had federal question removal jurisdiction over the Goepels' claims, as the Plan removed the case to district court on this basis alone, and it does not contend that it could have removed the case on the basis of diversity of citizenship. *See* 28 U.S.C. §§ 1332, 1441(a); *Caterpillar, Inc. v. Williams,* 482 U.S. 386, 392, 107 S.Ct. 2425, 2429 (1987) ("Absent diversity of citizenship, federal-question jurisdiction is required [for removal].").

" '[F]ederal question' cases . . . [are] those cases 'arising under the Constitution, laws, or treaties of the United States.' " *Metropolitan Life Ins. Co. v. Taylor,* 481 U.S.

58, 63, 107 S.Ct. 1542, 1546 (1987) (quoting 28 U.S.C. § 1331). "The presence or absence of federal-question jurisdiction is governed by the 'well-pleaded complaint rule,' which provides that federal question jurisdiction exists only when a federal question is presented on the face of the plaintiff's properly pleaded complaint." *Caterpillar, Inc. v. Williams,* 482 U.S. at 392, 107 S.Ct. at 2429 (citing *Gully v. First Nat'l Bank,* 299 U.S. 109, 112-13, 57 S.Ct. 96, 97-98 (1936)). " 'The rule makes the plaintiff the master of the claim,' " as generally " 'he or she may avoid federal jurisdiction' " by drafting a complaint which relies exclusively on state law. *Krashna v. Oliver Realty, Inc.,* 895 F.2d 111, 113 (3d Cir. 1990) (quoting *Caterpillar, Inc. v. Williams,* 482 U.S. at 392, 107 S.Ct. at 2429).

The Goepels' complaint does not purport to rely on federal law. Two of their its [sic] claims, namely the claims alleging violations of New Jersey's Law Against Discrimination, N.J. Stat. Ann. § 10:5-1 *et seq.*, and New Jersey's law against unfair claim settlement practices, N.J. Stat. Ann. § 17B:30-13.1, are based expressly on New Jersey statutes. *See* app. at 1-4, 8-10. Moreover, although the Goepels' breach of contract and unconscionability claims do not rely expressly on either state or federal law, in the absence of any indication that the Goepels intended to invoke federal common law, we conclude that "on their face" these claims are grounded exclusively on New Jersey common law.[3]

Nevertheless, the Plan argues that the Goepels' complaint "raises a federal question on its face" because it "seeks to enforce rights under a contract made by OPM pursuant to authority conferred by FEHBA," and "construction of that federal contract is governed exclusively by federal law." *See* br. at 32. Although the nature of the contract that the Goepels are seeking to enforce ulti-

[3] We do not reach the question of whether the Goepels could have stated a cause of action under federal common law.

mately may lead a court to find that their state claims are preempted, their complaint does not "raise a federal question on its face" merely by virtue of the fact that it alludes to a federal contract.[4] Thus, if the "well-pleaded complaint rule" were an unqualified bar to federal question jurisdiction, our analysis would end here, as on its face the Goepels' complaint does not raise a federal question. However, as we recognized in *United Jersey Banks v. Parell,* 783 F.2d 360, 366 (3d Cir.), *cert. denied,* 476 U.S. 1170, 106 S.Ct. 2892 (1986), "the issue is not as straightforward as the black letter law appears."

In *Franchise Tax Bd. v. Construction Laborers Vacation Trust,* 463 U.S. 1, 103 S.Ct. 2841 (1983), the Supreme Court "referred to two situations where federal jurisdiction could be available even though plaintiff based its claim in state court on state law: (1) when 'it appears that some substantial, disputed question of federal law is a necessary element of one of the well-pleaded state claims' or (2) when it appears that plaintiff's claim 'is "really" one of federal law.'" *United Jersey Banks v. Parell,* 783 F.2d at 366 (quoting *Franchise Tax Bd.,* 463 U.S. at 13, 103 S.Ct. at 2848). Subsequently, in *United Jersey Banks v. Parell,* we concluded that "[c]areful examination of the framework of the Court's analysis of the 'substantial, disputed question of federal law' issue" in *Franchise Tax Bd.* "manifests that the Court was not enuciating a new basis for federal jurisdiction but instead was reaffirming the traditional well-pleaded complaint test." *Id.* (citing *Franchise Tax Bd.,* 463 U.S. at 13-22, 103 S.Ct. at 2848-53). Accordingly, unless we determine that one of the Goepels' state claims "is 'really' one of federal law," *Franchise Tax Bd.,* 463 U.S. at 13, 103 S.Ct. at 2848, removal of the case to the district court was

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[4] *See Mulcahey v. Columbia Organic Chems. Co.,* 29 F.3d 148, 152-54 (4th Cir. 1994) (holding that a complaint's reference to federal environmental statutes as the basis for a claim alleging negligence *per se* did not suffice to state a claim arising under federal law).

improper, and we must order it remanded to the New Jersey Superior Court.

A state claim which is "really one of federal law" may be removed to federal court because "it is an independent corollary of the well-pleaded complaint rule that a plaintiff may not defeat removal by omitting to plead necessary federal questions in a complaint." *Franchise Tax Bd.*, 463 U.S. at 22, 103 S.Ct. at 2853. The Supreme Court has held that a state cause of action is "really" a federal cause of action which may be removed to federal court if the "federal cause of action completely preempts . . . [the] state cause of action." *Franchise Tax Bd.*, 463 U.S. at 24, 103 S.Ct. at 2854. This principle is "known as the 'complete preemption' doctrine," *Caterpillar, Inc. v. Williams*, 482 U.S. at 393, 107 S.Ct. at 2430, and it is "a distinct concept from ordinary preemption," *Railway Labor Executives Ass'n v. Pittsburgh & Lake Erie R. Co.*, 858 F.2d 936, 941 (3d Cir. 1988).[5] Thus, " '[t]he fact that a defendant might ultimately prove that a plaintiff's claims are pre-empted . . . does not establish that they are removable to federal court.' " *Id.* (quoting *Caterpillar, Inc. v. Williams*, 482 U.S. at 398, 107 S.Ct. at 2432).[6]

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[5] "This same principle has been referred to elsewhere as the 'artful pleading' doctrine, under which a court will not allow a plaintiff to deny a defendant a federal forum when the plaintiff's complaint contains a federal claim 'artfully pled' as a state law claim." *United Jersey Banks v. Parell*, 783 F.2d at 367 (citations omitted). *See also Federated Dept' Stores, Inc. v. Moitie*, 452 U.S. 394, 397 n.2, 101 S.Ct. 2424, 2427 n.2 (1981) ("As one treatise puts it, courts 'will not permit plaintiff to use artful pleading to close off defendant's right to a federal forum . . . [and] occasionally the removal court will seek to determine whether the real nature of the claim is federal, regardless of plaintiff's characterization") (quoting 14 C. Wright, A. Miller, & E. Cooper, Federal Practice and Procedure § 3722 at 564-66 (1976) (citations omitted)).

[6] "[I]t is now settled law that a case may *not* be removed to federal court on the basis of a federal defense, including the defense of pre-emption, even if the defense is anticipated in the plaintiff's complaint, and even if both parties concede that the federal

As we stated in *Railway Labor Executives Ass'n v. Pittsburgh & Lake Erie R. Co.*, 858 F.2d at 939,

> [t]he complete preemption doctrine holds that 'Congress may so completely preempt a particular area, that any civil complaint raising this select group of claims is necessarily federal in character.' *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 107 S.Ct. 1542, 1546, 95 L.Ed.2d 55 (1987). In such cases, 'any complaint that comes within the scope of the federal cause of action [created by the federal statute] necessarily "arises under" federal law,' *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 24, 103 S.Ct. 2841, 2854 (1983), for purposes of removal based on federal question jurisdiction.

The Supreme Court has held that both the Labor Management Relations Act (LMRA), and the Employee Retirement Income Security Act (ERISA) "completely preempt" certain state causes of action. The Supreme Court first applied the complete preemption doctrine in *Avco Corp. v. Aero Lodge No. 735*, 390 U.S. 557, 88 S.Ct. 1235 (1968), holding that Section 301 of LMRA "is so powerful as to displace entirely any state cause of action 'for violation of contracts between an employer and a labor organization.' " *Franchise Tax Bd.*, 463 U.S. at 23, 103 S.Ct. at 2853 (citing *Avco Corp. v. Aero Lodge No. 735*, 376 F.2d 337, 340 (6th Cir. 1967), *aff'd*, 390 U.S. 557, 88 S.Ct. 1235). Later, in *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. at 63-67, 107 S.Ct. at 1546-48, the Supreme Court held that ERISA completely preempted the common law contract and tort claims brought by an ERISA plan beneficiary asserting improper processing of a claim for benefits under the plan. However, in *Franchise Tax Bd.*, an earlier case, the Supreme Court held that

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defense is the only question truly at issue." *Caterpillar, Inc. v. Williams*, 482 U.S. at 393, 107 S.Ct. at 2430 (citing *Franchise Tax Bd.*, 463 U.S. at 12, 103 S.Ct. at 2847-48).

ERISA did not completely preempt "a suit by state tax authorities both to enforce . . . levies against funds held in trust pursuant to an ERISA-covered employee benefit plan, and to declare the validity of the levies notwithstanding ERISA." *Franchise Tax Bd.*, 463 U.S. at 28, 103 S.Ct. at 2856.

The Court in *Franchise Tax Bd.* based its determination that ERISA did not preempt a state law action by state tax authorities seeking to enforce a tax levy against an ERISA plan in part on the fact that ERISA "d[id] not provide an alternative cause of action in favor of the State to enforce its rights." *Id.* at 26, 103 S.Ct. at 2855. In contrast, section 301 of LMRA "expressly supplied the plaintiff in *Avco* with a federal cause of action to replace its pre-empted state contract claim," *id.*, and section 502(a) of ERISA expressly supplied the plaintiff in *Metropolitan* with a federal cause of action to replace his preempted state contract and tort claims, *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. at 65, 107 S.Ct. at 1547. Based on this distinction between *Franchise Tax Bd.*, on the one hand, and *Avco* and *Metropolitan*, on the other hand, we have held that the complete preemption doctrine applies only if "the statute relied upon by the defendant as preemptive contains civil enforcement provisions within the scope of which the plaintiff's state claim falls." *Railway Labor*, 858 F.2d at 942 (citing *Franchise Tax Bd.*, 463 U.S. at 24, 26, 103 S.Ct. at 2854-55). We also have identified a second prerequisite for the application of the complete preemption doctrine: "a clear indication of a Congressional intention to permit removal despite the plaintiff's exclusive reliance on state law." *Id.* (citing *Metropolitan Life*, 481 U.S. at 64-66, 107 S.Ct. at 1547-48).

Thus, based on our construction of *Franchise Tax Bd.*, "[t]he doctrine of complete preemption applies only when [these] two circumstances are present." *Allstate Ins. Co. v. The 65 Security Plan*, 879 F.2d 90, 93 (3d Cir. 1989). *See also Krashna v. Oliver Realty, Inc.*, 895 F.2d at 114

(applying the two facors identified in *Railway* and *Allstate* as prerequisites for the application of the complete preemption doctrine). We also have held that the only state claims that are "really" federal claims and thus removable to federal court, *Franchise Tax Bd.*, 463 U.S. at 13, 103 S.Ct. at 2848, are those that are preempted completely by federal law. *Railway Labor*, 858 F.2d at 942 ("If the federal statute creates no federal cause of action vindicating the same interest the plaintiff's state cause of action seeks to vindicate, recharacterization as a federal claim is not possible and there is no claim arising under federal law to be removed and litigated in the federal court.") (citing *Franchise Tax Bd.*, 463 U.S. at 24, 26, 103 S.Ct. at 2854-55) (footnote omitted).

Without applying the two-part test for complete preemption, which we have recognized as the only basis for recharacterizing a state law claim as a federal claim removable to a district court, the district court concluded that the removal was proper because the Goepels' complaint was " 'necessarily federal in character by virtue of the clearly manifested intent of Congress.' " *Goepel v. Mail Handlers Benefit Plan*, No. 93-3711, at 10 (D.N.J. Sept. 10, 1993) (quoting *Metropolitan*, 481 U.S. at 67, 107 S.Ct. at 1548). The district court cited FEHBA's language, its legislative history, and its resemblance to ERISA as evidence of Congress's intent to displace state law.

With respect to preemption, FEHBA states that

> [t]he provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

5 U.S.C. § 8902(m)(1). In some respects this provision does resemble ERISA's preemption provision, which states that "[e]xcept as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to an employee benefit plan." 29 U.S.C. § 1144(a).[7] Moreover, the district court noted that: "the legislative history [of FEHBA] makes it clear that its intent was to 'ensure that benefits and coverage under the program . . . [would] be uniform.'" *Goepel v. Mail Handlers Benefit Plan*, No. 93-3711, at 6 (D.N.J. Sept. 10, 1993) (quoting S. Rept. No. 903, 95th Cong. 2d Sess. 6, *reprinted in* 1978 U.S.C.C.A.N. 1413, 1417).

However, ERISA contains a civil enforcement provision expressly authorizing ERISA beneficiaries to bring actions to recover benefits under an ERISA plan. *See* 29 U.S.C. § 1132(a). In contrast, FEHBA does not create a cause of action vindicating a beneficiary's interest in recovering his or her benefits under a plan. FEHBA only provides that "[t]he district courts of the United States have original jurisdiction, concurrent with the United States Claims Court, of a civil action or claim against the United States founded on this chapter." 5 U.S.C. § 8912. But the United States is not a party to this action. Moreover, the regulations promulgated by OPM pursuant to FEHBA expressly provide that "[a]n action to recover on a claim for health benefits should

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[7] There is, of course, a distinction between the preemption provisions of ERISA and FEHBA. The former preempts "any and all state laws" having anything to do with employee benefit plans; the latter preempts state law relating to FEHBA health insurance or plans *only "to the extent that such law . . . is inconsistent with [a] contractual provision[]"* of an FEHBA policy. ERISA thus preempts all state law in a particular area. Under the FEHBA, however, there is no preemption, even in the area of FEHBA health insurance and plans, unless there is a conflict between the particular state law being relied upon in the litigation and a specific contractual provision in an FEHBA policy.

be brought against the carrier of the health benefits plan." *See* 5 C.F.R. § 890.107.[8] Although an enrollee "may ask OPM to review" a carrier's decision to deny a claim filed under a FEHBA plan, *see* 5 C.F.R. § 890.105(a), "an enrollee's dispute of an OPM decision solely because it concurs in a health plan carrier's denial of a claim is not a challenge to the legality of OPM's decision," and "[t]herefore, any subsequent litigation to recover on the claim should be brought against the carrier, not against OPM," *see* 5 C.F.R. § 890.107.[9]

Based on the language of FEHBA and the regulations promulgated pursuant to it, it is clear that FEHBA does not create a statutory cause of action vindicating the same interest that the Goepels' state causes of action seek to vindicate, namely the recovery of benefits from the Plan.[10] Consequently, we conclude that the complete preemption doctrine does not apply to the Goepels' claims, and thus "recharacterization" of their state claims as federal claims is "not possible" and "there is no claim arising under federal law to be removed and litigated in the federal court." *Railway Labor*, 858 F.2d at 942 (citing

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[8] Congress authorized OPM to "prescribe regulations necessary to carry out" the provisions of FEHBA. 5 U.S.C. § 8913(a).

[9] "Under a well settled principle of deference, 'considerable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer.'" *Katsis v. INS*, 997 F.2d 1067, 1069 (3d Cir. 1993) (quoting *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844, 104 S.Ct. 2778, 2782 (1984)), *cert. denied*, 114 S.Ct. 902 (1994).

[10] "There is currently a split of authority with respect to the exhaustion requirements for plans governed by FEHBA." *Kennedy v. Empire Blue Cross and Blue Shield*, 989 F.2d 588, 592 (2d Cir. 1993). We need not reach the question of whether a plaintiff *must* seek OPM review of the denial of a benefits claim prior to filing suit to recover benefits under a FEHBA plan or whether OPM review is optional, because in our opinion, even mandatory OPM review would not constitute a statutory federal cause of action vindicating an insured's interest in recovering benefits under a FEHBA plan.

Franchise Tax Bd., 463 U.S. at 24, 26, 103 S.Ct. at 2854-55).

We recognize that our decision is at odds with the decision by the Court of Appeals for the Fourth Circuit in *Caudill v. Blue Cross and Blue Shield of North Carolina*, 999 F.2d 74 (4th Cir. 1993). Like this case, *Caudill* involved a breach of contract claim brought in state court by a FEHBA plan enrollee seeking to recover benefits from her insurer. *Caudill*, 999 F.2d at 76-77. The insurer removed the case to the district court on the ground that plaintiff's claim "arose under" federal law, and the district court denied the enrollee's motion to remand. *Id.* at 77. Subsequently, on appeal, the United States Court of Appeals for the Fourth Circuit held that the removal was proper. *Id.* at 79. According to the court in *Caudill*, "[i]n the area of federal employee health benefits, federal common law entirely replaces state contract law," and "[t]herefore, federal jurisdiction existed over th[e] claim and removal was proper." *Id.* The *Caudill* court based its decision not on the complete preemption doctrine, but on *Boyle v. United Tech. Corp.*, 487 U.S. 500, 504, 108 S.Ct. 2510, 2514 (1988), a case which the district court in this case cited as an alternative basis for its denial of the Goepels' motion to remand.[11] *See Caudill*, 999 F.2d at 77; *Goepel v. Mail Handlers Benefit Plan*, No. 93-3711, at 10 (D.N.J. Sept. 10, 1993).

Boyle was a tort action brought by the father of a United States marine killed in a helicopter crash during a training exercise. *Boyle*, 487 U.S. at 502-03, 108 S.Ct. at 2513. The plaintiff alleged that the helicopter manufacturer was liable under Virginia tort law because the defective repair and design of the craft had caused the

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[11] The *Caudill* court concluded that in light of its holding, it "need not answer the question whether the FEHBA completely preempts state law claims under federal health insurance contracts." *Caudill*, 999 F.2d at 77.

accident. *Id.* at 503, 108 S.Ct. at 2513. The jury returned a general verdict in the plaintiff's favor, however, the court of appeals reversed, partially because it concluded that federal law immunized the helicopter manufacturer from state tort liability based on the allegedly defective design of the helicopter. *Id.* at 503, 108 S.Ct. at 2513-14.

The Supreme Court affirmed the court of appeals' determination that in the circumstances in *Boyle*, federal law displaced the "state law which holds Government contractors liable for design defects in military equipment." *Id.* at 512, 108 S.Ct. at 2518. The Court based this holding on two grounds: (1) that "the procurement of equipment by the United States is an area of uniquely federal interest," *id.* at 507, 108 S.Ct. at 2516, and (2) that in the circumstances in *Boyle*, there was a " 'significant conflict' . . . between an identifiable 'federal policy or interest and the [operation] of state law,' " *id.* (quoting *Wallis v. Pan American Petroleum Corp.*, 384 U.S. 63, 68, 86 S.Ct. 1301, 1304 (1966)).

The Court concluded that "the civil liabilities arising out of the performance of federal procurement contracts" involve a "uniquely federal interest," *id.* at 505-06, 108 S.Ct. at 2515, because "[t]he imposition of liability on Government contractors will directly affect the terms of Government contracts: either the contractor will decline to manufacture the design specified by the Government, or it will raise its price," *id.* at 507, 108 S.Ct. at 2515-16. Moreover, the court concluded that in some circumstances, state laws holding government contractors liable for design defects "present[ed] a 'significant conflict' with [the] federal policy," designed to insulate the government against financial liability for the performance of discretionary functions such as "the selection of the appropriate design for military equipment to be used by our Armed Forces." *Id.* at 511-12, 108 S.Ct. at 2518 (citing 28 U.S.C. § 2680(a)).

The *Boyle* court limited the scope of the displacement of state laws holding government contractors liable for design defects to the following circumstances: "(1) the United States approved reasonably precise specifications; (2) the equipment conformed to those specifications; and (3) the supplier warned the United States about the dangers in the use of the equipment that were known to the supplier but not to the United States." *Id.* at 512, 108 S.Ct. at 2518. However, the court indicated that "[i]n some cases, . . . where the federal interest requires a uniform rule, the entire body of state law applicable to the area conflicts and is replaced by federal rules." *Id.* at 508, 108 S.Ct. at 2516 (citations omitted).

Based on the two-part test applied in *Boyle*, the court in *Caudill* held that federal common law displaces state claims to recover benefits from a FEHBA plan. Like *Boyle, Caudill* was not an action brought by or against the United States. Nonetheless, the *Caudill* court made the following determination:

> [t]he interest in this case is uniquely federal because it involves health benefits for federal employees. . . [and because the] imposition of state law liability here would seriously damage not only the government's ability to enter into contracts with health insurers, but also would affect the price paid for such contracts. Most importantly, the federal government is a party to this contract. Thus, a significant federal interest exists here that is even stronger than in *Boyle.*

Caudill, 999 F.2d at 78. The court also concluded that the application of state law to the construction of a contract under FEHBA would present a "significant conflict" with the federal interest in uniformity evidenced by FEHBA's preemption provision and its provision authorizing OPM review of benefits decisions by insurers. *Id.* at 78-79. The court reasoned that

> [a]s an employer, the federal government has an overwhelming interest in ensuring that all of its employees subject to a particular health insurance policy are treated equally regardless of the state in which they live, and the application of state law interferes with this interest. . . . [Moreover,] the very application of state contract law would undermine the uniformity envisioned by Congress when it delegated the authority to interpret health benefit contracts to OPM.

Id. at 79. Thus based on the Supreme Court's decision in *Boyle*, the *Caudill* court concluded that removal of the case was proper because "[i]n the area of federal employee health benefits, federal common law entirely replaces state contract law." *Id.*

Our decisions in *Railway* and *Allstate* require us to reject the *Caudill* court's holding that *Boyle* authorizes the removal of a state law contract claim to recover benefits from a FEHBA plan. First, *Boyle* is distinguishable from this case because it did not involve the removal of "what purports to be a state law claim" from state court to federal court on the basis of federal question jurisdiction. *Railway*, 858 F.2d at 942. Instead, *Boyle* involved a state law claim initiated in federal district court on the basis of diversity jurisdiction. *Boyle*, 487 U.S. at 502, 108 S.Ct. at 2513. Thus, *Boyle* merely deals with a federal defense to a state claim and is therefore a preemption rather than a complete preemption case.

Second, in *Railway* and *Allstate*, we held that: (1) in a case removed from state court, a federal court may not recharacterize "what purports to be a state law claim as a claim arising under a federal statute" unless the state claim is completely preempted by federal law, *Railway*, 858 F.2d at 942, and that (2) a state claim is not preempted completely by federal law unless "the enforcement provisions of a federal statute create a federal cause of action vindicating the same interest that the plaintiff's cause of action seeks to vindicate," *Allstate*, 879 F.2d at

93. Thus, although the Supreme Court has stated that "the touchstone of the federal district court's removal jurisdiction is not the 'obviousness' of the pre-emption defense but the intent of Congress," *Metropolitan*, 481 U.S. at 66, 107 S.Ct. 1548, we have held that Congress must manifest its intent to authorize the removal of a state claim by enacting a federal statute containing an enforcement provision vindicating the same interest as the state claim.[12] Accordingly, we do not view the Supreme Court's decision in *Boyle* as an expansion of the complete preemption doctrine, and we reject the *Caudill* court's construction of *Boyle* as a case establishing an alternative basis for the removal of a state claim to federal court.

Our outcome is consistent with that reached in *Howard v. Group Hosp. Serv.*, 739 F.2d 1508, 1510-12 (10th Cir. 1984), in which the Court of Appeals for the Tenth Circuit held that the removal of an insured's state law tort and contract claims to recover benefits under a FEHBA plan was improper. However, unlike our decision, the decision in *Howard* did not rest on the lack of a federal statutory cause of action vindicating the same interests as the insured's state causes of action. In fact,

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[12] Our holding that a state claim is not preempted completely by federal law unless the enforcement provisions of a federal statute create a federal cause of action vindicating the same interest that the plaintiff's state cause of action seeks to vindicate is at odds with the holding in *Deford v. Soo Line R. R. Co.*, 867 F.2d 1080, 1086 (8th Cir.), *cert. denied*, 492 U.S. 927, 109 S.Ct. 3265 (1989). The court in *Deford* explicitly rejected our holding in *Railway* that because the Railway Labor Act lacked a civil enforcement provision under which the plaintiff could bring its state law claim, the Railway Labor Act did not preempt completely the plaintiff's state law claim. The *Deford* court stated that while our approach in *Railway* "sheds some light on whether a federal statute 'pervasively occupies' a field of law, it is unnecessarily narrow," as a court must look not only to "affirmative congressional intent and civil enforcement provisions, but . . . [also] to such factors as the history and purpose of the statute." *Deford*, 867 F.2d at 1086.

the court in *Howard* made no reference to the complete preemption doctrine.

Instead, the *Howard* court based its decision on its conclusion that the federal government had no "articulable interest in the outcome," *Howard*, 739 F.2d at 1510, of what it characterized as a "private controversy" between an insured and a carrier, *id.* at 1512. The court "fail[ed] to see how various state court adjudications of [FEHBA] . . . benefits claims . . . [would] frustrate the operation of that program or conflict with a specific national policy," and determined that "[s]tate court awards of monetary judgments in . . . [FEHBA] benefits actions do not have a sufficiently direct effect on the federal treasury to necessitate federal jurisdiction." *Id.* at 1511. On these grounds, the court concluded that state law, not federal law, controls actions to recover benefits under a FEHBA plan. *Id.* at 1510-12. *Cf. Howard v. Group Hospital Service*, 739 F.2d at 1513 (10th Cir. 1984) (concurring opinion) ("The majority opinion correctly concludes that no federal question jurisdiction is present in this case. However, the conclusion is reached after a lengthy and unnecessary discussion of whether federal law should apply to the interpretation of the insurance policy. Even if it were true that federal law should control the interpretation of the contract, that fact alone would be insufficient to establish a federal question giving rise to federal jurisdiction over the case. . . . Because the arguable federal question appears in this case by way of a defense to simple state law contract claims there is no basis for the exercise of federal question removal jurisdiction.").

We need not reach the question of whether the Goepels' state law claims are preempted by FEHBA, and thus are governed by federal common law. The courts are divided on the extent to which FEHBA preempts state law. As we noted, the court in *Howard* held that FEHBA does not preempt state law claims to recover benefits under a FEHBA plan. Nevertheless, " '[t]he weight of authority . . . supports the position that state law claims

are preempted,'" *Burkey v. Government Employees Hosp. Ass'n*, 983 F.2d 656, 659 (5th Cir. 1993) (holding that FEHBA preempts the application of Louisiana statute authorizing the imposition of penalties on plaintiff's insurer) (quoting *Federal Plaza Medical Assocs. v. Palermino*, 1991 WL 29201 (S.D.N.Y. 1991)). *See, e.g., Caudill*, 999 F.2d at 79 (holding that "[i]n the area of federal employee health benefits, federal common law entirely replaces state contract law"); *Nesseim v. Mail Handlers Benefit Plan*, 995 F.2d 804, 806 (8th Cir. 1993) ("[t]o ensure uniformity in the administration of benefits under the Act (and thus control costs), section 8902(m)(1) mandates that once the OPM enters into a benefits contract, that contract has the preemptive force of federal law") (citing 5 U.S.C. § 8902(m)(1)); *Harris v. Mutual of Omaha Companies*, 992 F.2d 706, 711-12 n.1 (7th Cir. 1993) (holding that federal common law of contracts governs the interpretation of government health insurance contracts) (citation omitted); *Hayes v. Prudential Ins. Co.*, 819 F.2d 921, 926 (9th Cir. 1987) (holding that FEHBA preempts all state law claims relating to a FEHBA plan), *cert. denied*, 484 U.S. 1060, 108 S.Ct. 1014 (1988); *Tackitt v. Prudential Ins. Co.*, 758 F.2d 1572, 1575 (11th Cir. 1985) ("the interpretation of government health insurance contracts is controlled by federal, not state, law"); *Fink v. Delaware Valley HMO*, 612 A.2d 485, 492-93 (Pa. Super. Ct. 1992) (holding that state tort claims brought by federal employee against HMO were preempted by FEHBA).[13] *But see Howard v. Group Hosp. Serv.*, 739

[13] With the exception of *Caudill*, none of these federal cases holding that FEHBA preempts state law claims for benefits deals expressly with the question of whether in the absence of diversity jurisdiction, FEHBA authorizes the removal of claims grounded exclusively on state law. It seems that *Nesseim*, *Harris*, *Burkey*, and *Tackitt* involved actions initiated in federal district court. The action in *Hayes* was initiated in state court and then removed to federal district court, *Hayes*, 819 F.2d at 923, but the *Hayes* court's opinion does not address the grounds for removal.

F.2d at 1512 (holding that removal of state law claims to recover benefits under a FEHBA plan was improper, as state law, not federal law governed the claims); *Mooney v. Blue Cross of Western Pennsylvania*, 678 F. Supp. 565, 566-67 (W.D. Pa. 1988) (following *Howard*, and holding that removal of state law claims to recover benefits under FEHBA plan was improper as "[t]here are no 'preempting' provisions in . . . [FEHBA], and absent an explicit instruction, we do not believe Congress intended the federal courts to fashion a federal common law of contracts to govern private disputes between plan participants and providers"); *Eidler v. Blue Cross Blue Shield United of Wisconsin*, 671 F. Supp. 1213, 1216-17 (E.D. Wis. 1987) (holding that insured's state law tort claim for bad faith was not preempted by FEHBA, as it was "not clear that the tort [wa]s inconsistent with any specific contractual provision").

The Plan is free to raise preemption as a defense in state court, and our holding that FEHBA does not completely preempt the Goepels' state law claims so as to permit removal of this action does not prejudge the merits of such a claim. "State courts are competent to determine whether state law has been preempted by federal law," *Railway*, 858 F.2d at 942, and absent complete preemption, "they must be permitted to perform that function" with regard to state law claims brought before them, *id.* Thus, based on our conclusion that the district court lacked subject matter jurisdiction over this case, we will reverse the order of September 10, 1993, denying the motion to remand, will vacate the order of September 24, 1993, entering judgment for the Plan on the merits, and will remand the matter to the district court so that it may remand the case to the Superior Court of New Jersey.

STAPLETON, Circuit Judge, *Concurring*:

I agree with all that is said in the opinion of the court. I write separately only to emphasize the importance, in my view, of the distinction noted by the court in footnote 7. Unlike the preemption provision of ERISA, the FEHBA preempts state law only "to the extent such law . . . is inconsistent with [a] contractual provision" of a FEHBA policy. 5 U.S.C. § 8902(m)(1). I believe the fact that Congress chose to so limit the preemptive effect of the FEHBA is inconsistent with the notion that Congress intended to "completely" preempt state law.

A True Copy:

Teste:

Clerk of the United States Court of Appeals
for the Third Circuit

APPENDIX B

[Filed Sep. 24, 1993]

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

HONORABLE JOSEPH E. IRENAS

Civil Action No. 93-3711 (JEI)

MARILYN GOEPEL and RONALD GOEPEL,
Plaintiffs

v.

MAIL HANDLERS BENEFIT PLAN,
Defendant

AMENDED OPINION AND FINAL JUDGMENT

IRENAS, District Judge

INTRODUCTION

Although on the surface this case presents a dispute between private parties concerning the interpretation of a health insurance contract, it is in reality an example of the trauma which the nation's current health care system is repeatedly creating.

As it exists today, our health care delivery system is to a great extent the product of free market competition, whether between doctors, hospitals, drug manufacturers, medical equipment suppliers or health insurance plans. The results of the free market have truly been a good news-bad news story.

The good news has been that for a particular individual with the right kind of insurance or personal wealth America probably offers the best health care available any-

where in the world. The bad news is that new and innovative technologies and treatment modalities, many of which were developed in response to competitive pressures, have driven up the cost of medical care to the point that this nation spends a greater percentage of its Gross National Product on health care than any other nation with a comparable standard of living. Moreover, despite this increasing expenditure, an ever-growing number of our citizens have neither the personal wealth nor the insurance coverage necessary to provide adequate health care.

Not only political reality, but also simple human decency, require that reasonable health care be made available to all our citizens. However, as the coming debate over President Clinton's new health care proposals [1] may demonstrate, making the best possible health care available to every citizen may cause the nation's health care costs to soar, regardless of the cost containment techniques implemented to control them. There is a growing list of medical treatments and procedures which cost hundreds of thousands of dollars, many of which have limited success rates, but many of which might be viewed as the only hope of survival by a desparately ill patient.

"Rationing" is an ugly word when used to describe the process by which society decides what medical procedures and services will generally be made available to the public by private wealth, through health insurance plans, or through government benefit programs such as Medicare and Medicaid. While we would all hope that any citizen would have access to the best possible health care, rationing by whatever name already is, and may well remain, a reality until further technological, scientific, or social advances reduce, rather than escalate, health care costs.

When the availability of health care is based on the personal wealth or employment of a particular individual,

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[1] A broad outline of these proposals was given at a joint session of the United States Congress on September 22, 1993.

or when insurers, like the defendant in this case, attempt to avoid either insolvency or soaring premiums by excluding expensive or innovative health care procedures, the process of rationing is at work, albeit on an uncoordinated and often unfair basis.

Plaintiffs Ronald and Marilyn Goepel filed a state court action seeking to compel the Mail Handlers Benefit Plan ("MHBP," or "the Plan") to pay for high dosage chemotherapy and an autologous bone marrow transplant for Marilyn Goepel. The suit was removed to the United States District Court for the District of New Jersey pursuant to 28 U.S.C. § 1441(b). Prior to this proceeding, plaintiffs filed a motion to remand the suit to the state court in New Jersey, which motion was denied by this Court. *See Goepel v. Mail Handlers Benefit Plan*, No. 93-3711, 1993 WL 347646 (D.N.J. Sept. 10, 1993).

This matter was tried on the merits pursuant to a joint stipulation of facts, and this Court now faces the painful task of deciding whether Mrs. Goepel is entitled to insurance coverage for the treatment requested—treatment which may be characterized as possibly life-saving.

Because we find (i) that the MHBP contract with the Office of Personnel Management ("OPM") does not by its terms provide coverage for autologous bone marrow transplants for breast cancer; (ii) that the Policy Brochure and related advertising materials were not sufficiently ambiguous or misleading as to prevent the plaintiffs from making an informed choice of coverage among the Federal Employee Health Benefit Act alternatives; and (iii) that MHBP insureds were given adequate notice of the revision in the text of the MHBP Plan Brochures from 1990 to 1991 which eliminated any ambiguity on the question of coverage for this procedure, plaintiffs' application for a permanent injunction barring MHBP from declining coverage will be denied, and judgment in favor of the defendant will be entered on all counts of the complaint.

FACTUAL BACKGROUND

Some of the facts have already been set forth in the opinion accompanying the order denying remand. The following summary is culled from the Joint Stipulation of the parties.

The Federal Employee[s] Health Benefits Act ("FEHBA," or the "Act"), 5 U.S.C. § 8901-13, governs the provision of health care benefits to federal employees and their families. Section 8902 of the Act authorizes the Office of Personnel Management ("OPM") to contract with private health insurance carriers, including health benefit plans provided by employee organizations, to offer health care plans to federal employees.

The provisions of the MHBP are renegotiated annually between the National Postal Mail Handlers Union (the "Union") and the Office of Personnel Management. When agreement is reached between the parties, a Plan Brochure is attached as an Appendix to the Standard Contract for Insurance. *See* Federal Employees Health Benefits Program, Standard Contract for Fee-for-Service Carriers Employee Organization Plan (the "Standard Contract"). The Plan Brochure serves two functions: it sets forth the extent of coverage offered by MHBP to insureds, and serves as the means of satisfying the notice requirements to FEHBA insureds set forth in 5 U.S.C. § 8907.

The coverage provisions contained within the Plan Brochure change yearly as a result of the negotiations between OPM and the Union. At the back of each Plan Brochure is a synopsis of changes and modifications entitled "How the Plan Changes," accompanied by a general admonition to the participants to "read the entire brochure carefully for a complete description of the Plan coverage." 1991 Plan Brochure at 30.

In years prior to 1991, the provisions of the Plan Brochure with respect to autologous bone marrow trans-

plants performed in conjunction with high dose chemotherapy were not clear. The Plan Brochures of 1988, 1989, and 1990, which were submitted to the Court along with the briefs for this hearing, arguably indicate that bone marrow transplants were covered only in cases involving leukemia. 1988 Plan Brochure at 9; 1989 Plan Brochure at 11; 1990 Plan Brochure at 11.[2] Discussion of high dose chemotherapy and autologous bone marrow transplats ("HDC/ABMT/APCR") was absent from the brochures.

In 1990, MHBP received ten requests for precertification of HDC/ABMT/APCR, which it initially denied.[3] It later reversed its decision, citing the arguable ambiguity of its Brochure provisions. Rather than litigate the ten denials, MHBP chose instead to grant precertification and clarify the provisions regarding covered bone marrow transplants in future brochures.

The 1991 Plan Brochure clarified MHBP's policy with respect to bone marrow transplants by limiting autologous and allogenic bone marrow transplants to specified medical conditions, which did not include breast cancer.[4] 1991 Plan Brochure at 16. In addition, the Plan brochure alerted participants to the clarification in the section

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[2] The section in the Plan Brochure that concerns organ transplants lists "bone marrow (for leukemia)" as a covered transplant. However, nothing in the section indicates whether the parenthetical was meant to be exemplary or exclusionary.

[3] At oral argument, counsel for the defendant indicated that these rejections were based on the "experimental" status of the treatment. Each Plan Brochure has a provision denying coverage for treatment deemed "experimental."

[4] "Benefits for autologous bone marrow transplants are limited to patients with acute leukemia in remission, resistant non-Hodgkins lymphomas, resistant or recurrent neuroblastoma, or advanced Hodgkins disease." 1991 Plan Brochure at 16.

"How the Plan Changes January 1991." 1991 Plan Brochure at 30.[5]

The 1991 Plan Brochure did not indicate, however, the circumstances under which such transplants would not be covered, and defendant continued to receive requests for HDC/ABMT/APCR precertification for enrollees with breast cancer. Insureds argued that despite the " are limited to" language in the Plan Brochure, the list of covered conditions was meant to be exemplary rather than exclusionary. Defendant denied the requests, and OPM upheld the denials based on its interpretation of the 1991 Plan provisions. One of these denials was reversed by the District Court of South Dakota in *Nesseim v. Mail Handlers Benefit Plan*, No. 92-1010 (D.S.D. 1992), but was later upheld by the Eighth Circuit. *Nesseim v. Mail Handlers Benefit Plan*, 995 F.2d 804 (8th Cir. 1993).[6]

The 1993 Plan Brochure attempted to foreclose all argument regarding the scope of coverage of bone marrow transplants. Immediately below the section in "Surgical Benefits" entitled "What is covered" was the following provision:

> What is not covered—Services or supplies for or related to surgical transplant procedures for artificial

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[5] "Coverage for bone marrow transplants has been clarified." 1991 Plan Brochure at 30.

[6] During the fourteen-month period in which *Nesseim* was appealed to the Eighth Circuit, defendant received four requests from participants with breast cancer for HDC/ABMT/APCR precertification. All four requests were denied, and OPM upheld the denials.

Of the four participants whose requests were denied, two of them ultimately received precertification from MHBP for the treatment requested. One of the women had filed suit, the other had threatened to file. Apparently, defendant was uncertain whether the district court's decision in *Nesseim* would be reversed, and preferred an appeal to the Eighth Circuit to relitigation at the district court level.

> or human organ/tissue transplants not specifically listed as covered, *such as autologous bone marrow transplants for breast cancer.* Related services or supplies include administration of chemotherapy when supported by transplant procedures.

Id. (emphasis added). As with the 1991 changes, MHBP placed additional notice of the clarification in the section "How the Plan Changes January 1993," stating that "substantial text revisions for clarity were made." *Id.* at 37. Participants were advised to "read [the Plan Brochure] carefully to understand your FEHB benefits." *Id.*

Plaintiff Ronald Goepel is a civilian employee of the Department of the Navy, and a participant in MHBP since 1981. Because Mr. Goepel enrolled in a "family coverage option" offered by the Plan, his wife Marilyn was also covered. In January, 1993, plaintiff Marilyn Goepel was diagnosed with metastatic breast cancer, Stage IV. Her treating physician immediately began a program of aggressive chemotherapy. Mrs. Goepel responded well to the aggressive chemotherapy, and her doctor recommended that he begin a program of high dose chemotherapy coupled with an autologous bone marrow transplant. *See* Certification of David L. Topolsky; Letter dated July 14, 1993, from David L. Topolsky to Mail Handlers Benefit Plan.

Plaintiff (via Dr. Topolsky) applied for precertification to commence the HDC/ABMT treatment. In addition, Linda Cathay, the Transplant Coordinator for Hahnemann University Hospital, with which Dr. Topolsky is affiliated, contacted MHBP about Mrs. Goepel's request. She was informed by "Julie in Customer Service" that the transplant procedure Mrs. Goepel requested was not covered under current Plan provisions. Letter dated August 6, 1993, from Representative Robert E. Andrews to Charlene Luskey at 1. However, when Ms. Cathay requested a written denial of benefits, "Julie" responded that such a letter would take four to six weeks. The letter of denial was issued on August 10, 1993.

At about the same time, Representative Robert E. Andrews from the First District of New Jersey contacted OPM on behalf of Mrs. Goepel. His letter relayed the events surrounding Mrs. Goepel's request for percertification and the difficulties she had encountered in obtaining a written denial. A response proceeded from Kenneth Lease at OPM, stating that OPM would probably uphold a denial of coverage for the treatment program requested.[7]

Plaintiffs filed suit in the Superior Court of New Jersey, Law Division—Camden County, on August 18, 1993. The complaint alleged a cause of action under the New Jersey Law Against Discrimination, N.J.S.A. 10:5 *et seq.*, as well as claims for breach of contract, unconscionability, and unfair trade practices. Defendant subsequently removed the case to the District of New Jersey based on the existence of federal jurisdiction under FEHBA. Plaintiffs filed a motion to remand, claiming the suit involved a contractual dispute governed by state law, which this Court denied on September 10, 1993.

LEGAL ANALYSIS

Plaintiffs' brief alleges three theories of recovery. The first two involve deliberately misleading information allegedly furnished by the defendant in the Plan Brochure and related advertisements, which prevented plaintiffs from making an informed decision as to appropriate health care coverage. Plaintiffs argue in their third claim that the clarification of bone marrow transplant coverage in 1991 was in fact a change of benefits of which plaintiff were not given proper notice.

The parties also contest the standard of review that should be applied to the OPM decision upholding MHBP's

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[7] The parties have stipulated, in light of any exhaustion requirement that may be implied from 5 U.S.C. § 8902(j), that the "exhaustion requirement was, in the circumstances of the case, satisfied by [the correspondence between Rep. Andrews and Mr. Lease of OPM]." Joint Stipulation at 12.

denial of coverage. We begin by examining the appropriate standard of review to be accorded the OPM determination.

I. *The Standard of Review*

The OPM "decision" at issue is not a formal determination of coverage, but rather a statement by Kenneth Lease that OPM would likely uphold MHBP's denial of coverage. Letter received August 10, 1993, from Kenneth Lease to Representative Robert Andrew[s] [hereinafter, "Lease Letter"]. Plaintiffs present various reasons why this Court should review the decision *de novo*. They argue that the agency's conclusion is one of law, which is reviewable *de novo* under both the Administrative Procedure Act ("APA"), 5 U.S.C. § 706, and applicable case law. *Broome v. U.S. Dept. of Labor*, 870 F.2d 95 (3d Cir. 1989). In the alternative, plaintiffs propose that where an insurer's denial of benefits stems from a conflict of interest (actual or potential) with its fiduciary duties, a reviewing court should give no deference to the decision. *See Wilson v. Group Hospitalization and Medical Services, Inc.*, 791 F. Supp. 309, 312 (D.D.C. 1992) (finding that decision of insurer in conflict of interest situation, due to dual role as insurer and administrator of plan, is not entitled to deference).

Defendant, on the other hand, contends that the decision to deny coverage to Mrs. Goepel is a final agency action, subject to review under an "arbitrary and capricious" standard. APA, 5 U.S.C. §§ 704, 706; *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 415 (1971) (holding that reviewing court is not empowered to conduct a *de novo* review of agency decision unless the agency action is adjudicatory in nature and the agency factfinding procedures are inadequate, or unless issues not raised before the agency are raised in a proceeding to enforce the agency's decision).

The administrative procedures used in the FEHBA setting are somewhat unique. While 5 U.S.C. § 8902(j) permits a plan participant to appeal the denial of benefits to OPM, such administrative review is not mandatory. In fact, neither FEHBA nor its implementing regulations give any insight into the elements of the appeal process or the criteria OPM is to use in reviewing the decision.[8]

The optional nature of § 8902(j) was discussed in *Skoller v. Blue Cross-Blue Shield of Greater New York*, 584 F. Supp. 288 (S.D.N.Y. 1984):

> While OPM's own regulations, 5 C.F.R. § 890.105, provide that an employee "may make a written request to OPM . . . for a review to determine whether the plan's denial is in accord with the [] terms of OPM's contract with the carrier of the plan," the regulatory language is clearly permissive. Moreover, 5 C.F.R. § 890.107 expressly provides for actions at law against the carrier of the health plan to recover on claims for health benefits. In sum, neither Congress nor OPM has manifested any intent to make OPM review either an exclusive remedy or a mandatory prerequisite to judicial resolution of disputes over contract interpretation.

Id. at 291.[9]

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[8] The relevant regulations only address basic submission requirements. 5 C.F.R. § 890.105.

[9] A related issue concerns whether § 8902(j) creates an exhaustion requirement for judicial review. The obligation to avail oneself of administrative procedures in the first instance as a predicate to seeking judicial relief from a government agency is clearly appropriate where the agency is vested with the exclusive authority to make specified types of determinations (*e.g.*, the granting of permits or licenses). It may also be appropriate where a government agency which has been granted decision-making authority also provides an opportunity to appeal an initial adminis-

Assuming a claimant submits to this optional administrative appeal, the issue then becomes the appropriate degree of deference to be accorded the OPM decision. On the one hand, the agency has been given authority under FEHBA to conduct such appeals, and presumably it has garnered certain expertise in the interpretation of insurance contracts as a result of that authority. Deference to OPM decisions would allow for greater uniformity in decisions, thereby reducing the need for litigation in the area.

However, this uniformity has its costs. Since the reality of the situation is that those seeking judicial review of OPM decisions are those who have been denied coverage, the practical effect of deference to an OPM decision would be to limit the scope of review available to those claimants who opted to submit to the OPM appeal process.

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trative decision or to move for reconsideration. *See Darby v. Cisneros*, 113 S.Ct. 2539 (1993) (holding, for cases contesting an initial determination by an administrative agency, that federal courts do not have the authority to imply an exhaustion requirement under the Administrative Procedure Act, 5 U.S.C. § 701 *et seq.*, where neither the statute nor agency rules specifically mandate same).

The parties have stipulated that any exhaustion requirements would be deemed satisfied by the correspondence between Representative Andrews and Kenneth Lease. However, where the defendant is not (and could not be, pursuant to 5 C.F.R. § 890.107) a government agency, where the administrative appeal from a private insurer's adverse coverage decision is not mandatory, and where there is no expressed Congressional intent to condition the right of one private party (the insured) to sue another private party (the insurer) on the filing of an OPM appeal, this Court doubts its ability to impose an exhaustion requirement as a predicate to judicial review.

We recognize that other courts have found that an insured must exhaust her remedies with OPM under § 8902(j) before seeking judicial review. *See, e.g., Kobleur v. Group Hospitalization and Medical Services, Inc.*, 954 F.2d 705 (11th Cir. 1992). Because the exhaustion issue is not before us, we need not decide whether the rationale of *Kobleur* is undermined by *Darby*.

To hinge a decision on the scope of judicial review of a coverage question on the fortuity of a claimant's decision to pursue an optional appeal to OPM might not only lead to courts reviewing the same issue in different cases with different standards of review, but might also discourage insureds from resorting to the simple OPM procedure for dealing with a coverage dispute.[10]

Even were this Court to find that deference to OPM decisions was appropriate in certain circumstances, Lease's statement that the MHBP denial would likely be upheld simply does not rise to the level of "agency action" that would be entitled to deference by a reviewing court. As such, we will review the decision to deny coverage *de novo*.

II. *Plaintiffs' Theories of Relief*

As stated earlier, the plaintiffs have posited three theories of coverage. The crux of each is that the defendant crafted the language used in the Plan Brochures, the advertisements circulated during Open Season, and the synopses of changes in benefits in order to obfuscate the true scope of coverage. As a result, plaintiffs were unable to ascertain their coverage under the MHBP policy until it was too late to change plans.

Since the first two, and perhaps all three, of plaintiffs' claims are essentially three variations on the theme of misrepresentation, they will be analyzed under the framework of 5 U.S.C. § 8907, which governs the information that

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[10] We are aware of the argument made by plaintiffs that OPM has delegated the responsibility for making coverage decisions to the insurance carriers. However, because of the fixed-fee contract which the carrier receives, there remains the potential for conflict of interest. *See Wilson v. Group Hospitalization and Medical Services, Inc.*, 791 F. Supp. 309, 312 (D.D.C. 1992) (finding that, since insurer who served additional role as plan administrator was subject to conflict of interest, insurer's decision was entitled to no deference).

must be furnished to participants in health plans contracted under FEHBA. Section 8907(a) requires carriers to

> make available to each individual eligible to enroll in a health benefits plan under this chapter such information, in a form acceptable to the Office after consultation with the carrier, as may be necessary to enable the individual to exercise an informed choice among the types of plans [governed by FEHBA].

Id. The issue for each of plaintiffs' claims is whether the text chosen for the brochures and ads was sufficiently ambiguous or misleading as to prevent the plaintiffs from exercising an informed choice among health care alternatives.

A. *Deliberate Confusion in the Plan Brochure*

The plaintiffs first allege that the defendant deliberately obfuscated the scope of coverage in the Plan Brochure itself. The argument is as follows: Plan Brochures of years past failed to pin down with an specificity the Plan's coverage of bone marrow transplants, an ambiguity which allowed defendant to later deny coverage. When the defendant was finally compelled, because of mounting litigation costs, to clarify its policy with respect to bone marrow transplants, it did so by scattering the relevant provisions throughout the Plan Brochure. Plan participants were thus compelled to decipher the various sections of the brochure in order to ascertain fully the scope of coverage.

The Court first notes that the only Plan Brochure that may be considered under this theory is the one covering the 1993 plan period, during which Mrs. Goepel was first diagnosed with breast cancer and first attempted to obtain precertification. Since MHBP contracts annually with OPM, the misrepresentations, if any, contained in prior brochures would not be relevant to the extent of coverage offered in the 1993 Plan Brochure.

Therefore, we must examine the 1993 Plan Brochure to determine if its provisions are misleading enough to preclude the exercise of an informed choice of coverage. After examining the Brochure, this Court finds no indication that the provisions are deliberately misleading. On the contrary, page 15 of the 1993 Plan Brochure, which discusses organ and tissue transplants, specifically notes that "[c]hemotherapy when supported by bone marrow transplant or autologous stem cell support is covered only for specific diagnoses listed on page 19." On page 19, the Brochure specifically excludes, in a section entitled "What is not covered," the very treatment Mrs. Goepel seeks. There is simply no ambiguity in the provisions of the 1993 Plan Brochure.

Even if we were to find that defendant had made deliberate misrepresentations in the text of the Plan Brochure, it is unclear that such actions would give rise to a private cause of action. Brochures and related summaries of benefits for plans negotiated under FEHBA, such as the brochures received by the Goepels, are subject to OPM approval before distribution. 5 U.S.C. § 8907; Standard Contract at § 1.13. Since the Plan Brochure distributed to the Goepels had been approved by OPM, the defendant may have a "safe harbor" for compliance with federal provisions. Moreover, a review of the relevant statutes and regulations does not reveal a private cause of action for misrepresentation. The one jurisdiction that has examined the area did not think that "[s]ection 8907 creates a private right of action for health care subscribers and that plaintiffs therefore do no[t] have standing to assert this claim." *Zeigan v. Blue Cross & Blue Shield of Greater New York*, 607 F. Supp. 1434, 1438 (S.D.N.Y. 1985). Irrespective of the existence of a private cause of action, we do not find either that there is ambiguity in the coverage provisions relating to bone marrow transplants or that the information contained in the 1993 Plan Brochure prevented the exercise of an informed decision.

B. *Deliberate Misrepresentations in the Accompanying Advertising*

Plaintiffs next challenge the advertisements and pamphlets used to advertise the Plan. Many of these pamphlets have been provided to the Court for inspection. They are full-color, replete with photographs of smiling participants and charts proclaiming the benefits of the MHBP Plan. *See* Exhibits to Joint Stipulation, Exhibit I-1 to I-14; Exhibits C-2-A to C-2-D. The pamphlets also tout the various increases in benefits and/or coverage achieved during the preceding year. Frequently repeated terms include such slogans as "more value," "benefit increase," "comprehensive coverage," and "improved coverage." Interested parties are even referred to a toll-free number for further information and assistance.

Important to this case is the textual layout of the brochures, which is governed by the advertising requirements set forth in the Standard Contract between OPM and the National Postal Mail Handlers Union, administrator of the Mail Handlers Benefit Plan. Section 1.14 of the Standard Contract contains a general prohibition against "misleading, deceptive or false advertising," and directs carriers to consult the *FEHB Supplemental Literature Guidelines* and the *NAIC Rules Concerning Advertising of Accident and Sickness Insurance with Interpretive Guidelines* in assembling advertising pamphlets. The latter two publications offer specific guidelines for the form and content of the advertisements, including permitted and proscribed phrases, proper typesetting, and disclosure requirements. Taken together, the Standard Contract and the guidelines provide the basic OPM standards for advertising of FEHBA plans.[11]

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[11] It should be noted that carriers are not, as plaintiff states, required to comply with the full panoply of directives contained in the *Supplemental Literature* or *NAIC Guidelines*. Rather, the

In order to understand plaintiffs' argument, it is necessary also to understand what happens during the "Open Season." At least once each year, OPM reviews its contracts with FEHBA carriers and makes appropriate adjustments, which can include modification of provisions along with addition and deletion of carriers. After these adjustments are made, an "Open Season" is declared during which federal employees who are not participants in a FEHBA plan are given the opportunity to enroll, and current participants are given the opportunity to change plans. To publicize the benefits of their particular plans, FEHBA carriers disseminate advertisements during the Open Season containing coverage summaries.

Plaintiffs' argument is straightforward: Defendant's advertisements, with their constant invocations of "comprehensive coverage" and "increased benefits," fail to inform eligible federal employees of the true scope of plan coverage. In fact, plaintiffs allege, the advertisements are so deficient as to be misleading to a person of average education or intelligence.[12] As a result, plaintiffs contend, interested parties are prevented from exercising an informed choice as to health care coverage.

Plaintiffs assert that their argument is even stronger with respect to current enrollees in a FEHBA plan. Federal employees who are already enrolled in a plan are even less likely to engage in a full brochure-by-brochure comparison of benefits. Instead, these employees are dependent on the advertisements to indicate the appropriate form

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guidelines are merely used as criteria to assess compliance with the general proscription against advertising that is misleading, deceptive, or unfair.

[12] Plaintiffs assert incorrectly that defendant's failure to comply fully with the text of the two guidelines referred to in the Standard Contract constitutes a violation of its contract with OPM. As discussed in the preceding footnote, the guidelines are merely suggested criteria for assessing compliance, and are not themselves part of the contract with OPM.

of health care coverage. Thus, they are even more susceptible to misleading advertisements that fail to mention reductions in benefits or qualifications on coverage.

While there can be little doubt that, like the old song, the advertisements "accentuate the positive. . .," the materials submitted to this Court include explicit reference to further qualifications by using phrases such as "covered benefits," "covered doctor's visits," and "covered surgery." In addition, each of the advertisements contains the following disclaimer:

> This is a summary (or brief description) of the features of the Mail Handlers Benefit [or High Option] Plan. Before making a final decision, please read the Plan's officially approved brochure. All benefits are subject to the definitions, limitations and exclusions set forth in the official brochure.

Even without the disclaimer, it is doubtful that federal employees, particularly those of "average education or intelligence," would enroll in a particular health care program on the basis of the advertisements alone. To say that advertisements prevent an informed decision is to overestimate their persuasive or informative power.

As with the preceding theory of liability, it is not apparent to the Court that a private right of action exists for misrepresentations in advertising. Not only does § 1.13(b) forbid the distribution of marketing materials not "reviewed and approved" by OPM,[13] but § 1.14(c), which deals with remedies for untruthful or misleading advertising, also gives OPM the authority to reduce the service charge or take "corrective action to protect the

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[13] Standard Contract at § 1.13(b) provides as follows: "The Carrier shall not distribute or display marketing materials or other supplemental literature in a Federal facility or arrange for the distribution of such documents by Federal agencies unless the documents have been reviewed and approved by the OPM."

interest of Federal Members." [14] Neither provision appears to afford any rights to enrollees who may be injured by the false advertisements.[15]

C. *Failure to Notify of Change in Benefits*

The provisions outlining MHBP's coverage for bone marrow transplants in Plan Brochures prior to 1991 were ambiguous. The Plan Brochures for 1988 through 1990 merely listed "bone marrow (for leukemia)" among the covered organ transplants.[16] In 1990, based on its realization that plan provisions might be ambiguous, defendant allowed the precertification of 10 women for HDC/ABMT, and set out to clarify the language in the next brochure. Thus, the 1991 Plan Brochure sets forth an exclusive list of medical conditions for which a bone marrow transplant would be a covered procedure.

Plaintiffs contend that, in allowing the precertification of ten claimants in 1990, defendant in effect conceded that HDC/ABMT was a covered benefit under the 1990 Plan Brochure. Therefore, when defendant changed the

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[14] The examples mentioned in the provision include orders to cease and desist publication of the offending material or to publish corrections. Repeated offenses can result in a suspension of new enrollments or a termination of the contract with OPM. Standard Contract at § 1.14(c).

[15] Courts are generally reluctant to imply private causes of action from regulatory enactments, absent some indication of legislative intent. *See Cort v. Ash*, 422 U.S. 66, 78 (1975); *Middlesex Cty. Sewerage Auth. v. National Sea Clammers Assoc.*, 453 U.S. 1, 13 (1981); *Miller v. Zoby*, 250 N.J. Super. 568, 577 (App. Div. 1991).

[16] Counsel for the defendant stated in oral argument that the phrase "bone marrow (for leukemia)" indicated that bone marrow transplants would only be covered in cases involving leukemia. It is certainly arguable that plan participants could easily have believed that the parenthetical was merely exemplary of the conditions for which bone marrow transplants would be covered. *See supra* note 2 and *infra* note 17.

Plan Brochure in 1991 to specify the medical conditions for which HDC/AMBT would be allowed, the resulting change was not, as defendant characterizes it, a clarification, but rather an express change in benefits.[17] Since defendant's Plan Brochure specifically states that changes in benefits are listed in a particular section, and since defendant did not list the relevant textual changes in that section, plaintiffs conclude that defendant improperly restricted coverage without notice to the participants.[18]

We agree with the plaintiffs that 1991 marked a significant change in the language of the Plan regarding covered bone marrow transplants.[19] However, we disagree with their contention that this change could not be fairly

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[17] The statement by defendant's counsel at oral argument, to the effect that the ten initial denials were predicated only on the "experimental" status of the treatment, lends support to plaintiffs' claim. After all, if the parenthetical "(for leukemia)" truly represented limiting language, defendant could have denied precertification on that basis alone, and not run the risk of further litigation over whether the treatment was experimental. *See Heasley v. Belden & Blake Corp.*, No. 92-3681, 1993 WL 284519 (3d Cir. July 30, 1993) (discussing criteria under which a procedure is to be determined "experimental").

[18] Pages 29 and 30 of the 1991 Plan Brochure contain a section captioned "How The Plan Changes." That section contains various subsections, two of which are entitled "Benefit Changes" and "Clarifications." The latter subsection states that "[c]hanges in the language used in this brochure are not intended to change any benefit unless described as Benefit Changes above." There is no reference to bone marrow transplants in Benefit Changes, while the Clarifications subsection notes that "coverage for bone marrow transplants has been clarified."

[19] Counsel for the plaintiffs also indicated at oral argument that the changes reflected in the 1993 Plan Brochure were similarly significant. However, the Court finds that the 1993 changes were nothing more than additional clarification of Plan provisions. Even had the 1993 changes not been made, this Court would not find the Plan provisions concerning bone marrow transplants to be ambiguous.

characterized as a clarification of existing coverage rather than an express change in benefits.

It was certainly arguable that the pre-1991 Plan Brochures either expressly limited coverage for autologous bone marrow transplants to treatment for leukemia or implicitly excluded coverage under the general provision dealing with experimental procedures. In allowing precertification of the ten women in 1990, defendant was not necessarily conceding a contractual right to the benefit. It might just as reasonably have concluded that paying for the treatment requests for that one year would cost less than litigating the issue. Under such circumstances, the 1991 revisions were nothing more than clarifications, and the notation of modifications in "How the Plan Changes 1991" was sufficient to put participants on notice.

This Court is also troubled by the invitation to recognize a cause of action, not based on the fact that the policy was unclear, but rather, as plaintiffs suggest, on the premises that insureds (1) do not read the full brochure detailing policy coverage and (2) do not heed the admonition in the section on "How the Plan Changes" to review the entire policy.[20] Such presumed conduct is a poor foundation on which to build a cause of action against a FEHBA carrier, especially one whose brochures have been approved by a government agency prior to distribution.

Neither the federal or state courts are the proper vehicles to make health care policy, a task which our constitutional system leaves to the legislative and executive

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[20] Page 30 of the 1991 Plan Brochure provides:

> The language in this brochure, especially the language in *General Exclusions, How to Claim Benefits,* and *Medicare,* has been modified. You should read the entire brochure carefully for a complete description of Plan coverage. Changes in the language used in this brochure are not intended to change any benefit unless described as Benefit Changes above.

branches of our state and federal governments. As a court sworn to uphold the Constitution, we have decided the dispute before us on the law as we understand it. This may be one of the unusual instances where a determination by an appellate court that our legal understanding was erroneous would cause neither the court nor anyone else involved in this case any personal unhappiness. However, in the final analysis, the pain of health care rationing must be dealt with in the political arena, not in the courts.

For the reasons set forth above,

IT IS on this 24th day of September, 1993,

ORDERED THAT the plaintiffs' application for a permanent injunction be, and the same hereby is, DENIED, and judgment be, and the same hereby is, entered in favor of the defendant on all counts of the complaint.

/s/ Joseph E. Irenas
JOSEPH E. IRENAS
U.S.D.J.

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 93-5657

MARILYN GOEPEL; RONALD GOEPEL,
Appellants

v.

NATIONAL POSTAL MAIL HANDLERS UNION,
A DIVISION OF LIUNA, d/b/a MAIL
HANDLERS BENEFIT PLAN

On Appeal from the United States District Court
for the District of New Jersey
(D.C. Civil No. 93-03711)

SUR PETITION FOR REHEARING

BEFORE: SLOVITER, *Chief Judge,* and BECKER, STAPLETON, MANSMANN, GREENBERG, HUTCHINSON, SCIRICA, COWEN, NYGAARD, ALITO, ROTH, LEWIS, and MCKEE, *Circuit Judges,* and ATKINS, *District Judge* *

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* Honorable C. Clyde Atkins, Senior United States District Judge for the Southern District of Florida, sitting by designation.

The petiiton for rehearing filed by the appellee, Mail Handlers Benefit Plan, in the above captioned matter having been submitted to the judges who participated in the decision of this court and to all the other available circuit judges of the court in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular active service not having voted for rehearing by the court in banc, the petition for rehearing is denied.

BY THE COURT:

/s/
Circuit Judge

Dated: Oct. 25, 1994

APPENDIX D

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 93-5657

MARILYN GOEPEL; RONALD GOEPEL,
Appellants

vs.

NATIONAL POSTAL MAIL HANDLERS UNION,
A DIVISION OF LIUNA, d/b/a MAIL
HANDLERS BENEFIT PLAN

On Appeal from the United States District Court
for the District of New Jersey
(D.C. Civ. No. 93-03711)

PRESENT: STAPLETON and GREENBERG, *Circuit Judges*, and ATKINS, *District Judge**

JUDGMENT

This cause came on to be heard on the record from the United States District Court for the District of New Jersey and was argued by counsel on August 2, 1994.

On consideration whereof, it is now here ordered and adjudged by this Court that the judgment of the said Dis-

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* Honorable C. Clyde Atkins, Senior United States District Judge for the Southern District of Florida sitting by designation.

trict Court dated September 10, 1993 and entered September 13, 1994, be, and the same is hereby reversed and the judgment entered September 24, 1993 is hereby vacated. The cause is remanded to the District Court so that it may remand the case to the Superior Court of New Jersey. Costs taxed against appellee. All of the above in accordance with the opinion of this Court.

ATTEST:

/s/ Bradford A. Baldus
BRADFORD A. BALDUS
Chief Deputy Clerk

Dated: September 27, 1994

Certified as a true copy and issued in lieu of a formal issued mandate on November 2, 1994

Teste:

/s/ P. Douglas Sisk
Clerk
U. S. Court of Appeals
for the Third Circuit

APPENDIX E

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 93-5657

MARILYN GOEPEL and RONALD GOEPEL,
Appellants

vs.

NATIONAL POSTAL MAIL HANDLERS UNION, *et al.*

It is ORDERED that the motion for recall of the mandate is DENIED because no substantive right of the applicant will be affected by failure to grant the recall of the mandate. This is without prejudice to the applicant's right to file a timely petition for writ of certiorari.

/s/
Circuit Judge

Dated: Nov. 25, 1994

APPENDIX F

[Filed Sep. 10, 1993]

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

HONORABLE JOSEPH E. IRENAS

Civil Action No. 93-3711 (JEI)

MARILYN GOEPEL and RONALD GOEPEL,
Plaintiffs

v.

MAIL HANDLERS BENEFIT PLAN,
Defendant

OPINION AND ORDER

IRENAS, District Judge

This motion for remand presents the issue of whether a dispute involving the terms and scope of coverage under a federally-sponsored health benefits plan presents a federal question. Plaintiffs Ronald and Marilyn Goepel filed a state court action seeking to compel the Mail Handlers Benefit Plan ("MHBP") to pay for high dosage chemotherapy and an autologous bone marrow transplant for Marilyn Goepel.

After defendants removed the case to the District of New Jersey, plaintiffs moved to remand, claiming that the matter is merely a contractual dispute governed by state law. Because plaintiffs' complaint involves a uniquely federal interest and a significant conflict between state and federal law, the matter is one "arising under" the laws of the United States and is removable under 28 U.S.C. § 1441(b). Plaintiffs' motion to remand, therefore, is hereby denied.

I. BACKGROUND

Plaintiff Ronald Goepel is employed by the U.S. government and participates in the MHBP, which provides health insurance and benefits for federal employees and their families. His wife, plaintiff Marilyn Goepel, has metastasized breast cancer which is considered as Stage IV. She is seeking to treat this condition with high dose chemotherapy, coupled with an autologous bone marrow transplant. The 1993 MHBP Brochure, which sets forth the terms of the Goepels' coverage, provides:

> Chemotherapy when supported by bone marrow transplant or autologous stem cell support is covered only for specific diagnoses listed on page 19.

Brief in Support of Plaintiffs' Motion to Remand, Exh. 4, p. 15 [hereinafter Plan]. Page 19 contains information about which transplants are covered, as well as a generalized statement of what is not covered:

> What is not covered—Services or supplies for or related to surgical transplant procedures for artificial or human organ/tissue transplants not specifically listed as covered, such as autologous bone marrow transplants for breast cancer.

Id. at 19.

The Goepels sought pre-certification from the defendant for the transplant procedure as required by the contract, but were apparently turned down. There is no indication in the complaint that any administrative action was taken to reverse this decision by appealing to the Office of Personnel Management ("OPM") as provided in 5 U.S.C. § 8902(j).[1] The existence of this administrative route of appeal, and its role in the scheme of things, is discussed further in the opinion.

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[1] At oral argument counsel agreed that in response to an inquiry from Goepel's Congressman, Honorable Robert Andrews, OPM indicated in writing that on appeal it would have sustained MHBP's denial of benefits.

The Goepels commenced the within action in the Superior Court of New Jersey, Law Division—Gloucester County. The complaint filed by plaintiffs seems to allege the following:

1. A breach of New Jersey's law against discrimination. N.J.S.A. 10:5 *et seq.*

2. A simple breach of contract coupled with the notion that there was some improper change in the benefit package between 1988 and 1993.

3. Unconscionability

4. Unfair Trade Practices

The case was subsequently removed by the defendant pursuant to 28 U.S.C. § 1441 and § 1446.

Presently before the court is plaintiffs' motion to remand on the grounds that the dispute does not involve a federal question, but is rather a private contractual dispute between an insured and a health care insurer that is governed by state law. The remainder of this opinion will discuss plaintiffs' arguments in light of the provisions of the Federal Employees Health Benefit Act ("FEHBA," or "the Act"), the scope of preemption intended by the Act, and the existence *vel non* of federal jurisdiction.

II. THE FEDERAL EMPLOYEES HEALTH BENEFITS ACT

Health insurance for federal employees is provided pursuant to the provisions of FEHBA, 5 U.S.C. §§ 8901-13. Stated simply, the Act provides that the OPM can contract with private health insurance carriers, including health benefits plans provided by employee organizations, to provide health insurance to federal employees. *Id.* §§ 8902(a), 8903. Various other provisions of the Act allow OPM to determine the minimum standards for such plans, *id.* § 8902(e), eligibility requirements and elections of coverage, *id.* §§ 8905 and 8905a, the cost to be

charged for the coverage offered, *id.* § 8906, and the qualification of insurers to offer coverage, *id.* § 8902(a). Section 8907 of the Act governs the type of information which must be provided to employees who are eligible to enroll or do in fact enroll in a particular plan. Finally, § 8906(b) details the government contributions which are used to defray a substantial portion of the cost of this insurance—as much as 75%.

Section 8913 of the Act gives OPM the right to promulgate regulations to carry out the intent and purposes of the Act. Even though, as noted earlier, § 8902(j) gives an employee who is denied benefits by a carrier the right of administrative appeal to OPM,[2] 5 C.F.R. § 890.107 provides that:

> An action to recover on a claim for health benefits should be brought against the carrier of the health benefits plan. . . . [A]n enrollee's dispute of an OPM decision solely because it concurs in a health plan carrier's denial of a claim is not a challenge to the legality of OPM's decision. Therefore, any subsequent litigation to recover on the claim should be brought against the carrier, not against OPM.

Thus, although § 8912 gives the District Court jurisdiction over claims under the Act which are against the United States, the United States is not a party to the typical coverage dispute.

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[2] Whether § 8902(j) implies an obligation to exhaust administrative remedies is not presently an issue, but has been considered by other courts. *See, e.g., Caudill v. Blue Cross and Blue Shield of North Carolina, Inc.*, No. 92-2259, 1993 U.S. App. Lexis 10042 (4th Cir. Apr. 29, 1993) (Reported in Table Case Format at 993 F.2d 228); *Nesseim v. Mail Handlers Benefit Plan*, 995 F.2d 804, 16 E.B.C. 2465 (8th Cir. 1993); *Kobleur v. Group Hospitalization & Med. Services*, 954 F.2d 705 (11th Cir. 1992).

III. PREEMPTION

The Act preempts state or local law or regulation which relates to health insurance or plans "to the extent that such law or regulation is inconsistent with such contractual provisions." § 8902(m)(1). While the parties dispute the meaning of this inartfully drafted provision, the legislative history makes it clear that its intent was to "ensure that benefits and coverage under the program will be uniform." S. Rept. No. 903, 95th Cong., 2d Sess. 6, *reprinted in* 1978 U.S.C.C.A.N. 1413, 1417. It is also clear that Congress wanted to preserve to the States not only the right to regulate general insurance matters "such as the payment of premium taxes and requirements for statutory reserves," *id.* at 1415, but also the rights of the state "to control the licensing of health practitioners," to control "who is and who is not qualified to provide health care," and to develop "innovative health techniques," *id.* at 1416.

Despite the difference in language, these statements appear to be a congressional attempt to achieve the same type of preemption which is found in the ERISA statute, 29 U.S.C. §§ 1144(b)(2)(A), 1144(a), and 1144(b)(2)(B)—language which itself "perhaps [is] not a model of legislative drafting." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987). In both ERISA and FEHBA, Congress wished to leave to the States the broad right to regulate in matters of public concern (*e.g.*, insurance, health care), while at the same time creating uniformity among the states in determining the benefits to which an employee is entitled. *See Hayes v. Prudential Ins. Co. of America*, 819 F.2d 921, 925 (9th Cir. 1987) ("The policy underlying section 8902(m)(1) is to ensure uniformity in the administration of FEHBA benefits."; finding inconsistent state legislation preempted by FEHBA).[3]

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[3] Cases decided under FEHBA have accorded OPM decisions reviewing a denial of benefits the deferential "arbitrary and ca-

IV. JURISDICTION

United States District Courts have original jurisdiction of all civil actions arising under the "Constitution, laws, or treaties of the United States." 28 U.S.C. § 1331. Such civil actions are removable to the District Court pursuant to 28 U.S.C. § 1441(b). Plaintiffs argue in this motion that this case is not one arising under the law of the United States and, to some extent, frame the issue as one of interpreting the scope of the preemption intended by 5 U.S.C. § 8902(m)(1).

The primary case cited by plaintiff in support of this position is *Howard v. Group Hosp. Service*, 739 F.2d 1508 (10th Cir. 1984). There, the Tenth Circuit found that, while a Blue Cross contract was a federal contract authorized by federal law, disputes between the parties were "private controversies" in which the federal government lacked jurisdiction. *Id.* at 1512. Although a smattering of cases have followed this position, the overwhelming number of cases involving disputes between a federal employee and an insurer have expressly or implicitly assumed the existence of federal jurisdiction. *See, e.g.,*

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pricious" and "plainly erroneous" standards of review. *Caudill v. Blue Cross and Blue Shield of North Carolina, Inc.*, No. 92-2259, 1993 U.S. App. Lexis 10042 (4th Cir. Apr. 29, 1993), as *6; *Myers v. United States*, 767 F.2d 1072, 1074 (4th Cir. 1985).

The Plan provides that federal law governs all claims for relief. Plan at 33. Since § 8903 allows OPM to "contract *or approve*" particular health plans, while § 8902(d) allows OPM to include "such maximums, limitations, exclusions, and other definitions of benefits *as [OPM] considers necessary or desirable*" (emphasis added), it might be argued that this choice of law provision in the Plan amounts to an OPM interpretation of FEHBA which should be respected by a reviewing court. *INS v. Cardoza-Fonseca*, 480 U.S. 421, 488 (1987); *see also Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843 (1984); *Katsis v. INS*, 997 F.2d 1067, 1069-70 (3d Cir. 1993).

Apart from any jurisdictional considerations, there may also be an issue of whether the choice of federal law in the Plan should be given effect as a simple matter of contract law.

Caudill v. Blue Cross and Blue Shield of North Carolina, Inc., No. 92-2259, 1993 U.S. App. Lexis 10042 (4th Cir. Apr. 29, 1993) (Reported in Table Case Format at 993 F.2d 228); *Neisseim v. Mail Handlers Benefit Plan*, 995 F.2d 804, 16 E.B.C. 2465 (8th Cir. 1993); *Hayes*, supra; *Tackitt v. Prudential Ins. Co. of America*, 758 F.2d 1572 (11th Cir. 1985). Not only is the weight of authority against the plaintiff, but the more recent authority casts doubt on the precedential value of *Howard* and supports a finding of federal jurisdiction in this type of dispute.

Since *Howard* was decided the Supreme Court has decided *Pilot Life Insurance Co. v. Dedeaux*, *supra*, and *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987), ERISA cases which make clear that a coverage dispute between an employee in the private sector and a private health insurance carrier is a dispute arising under the laws of the United States over which the District Court has jurisdiction. The rationale of those decisions is even more compelling when applied to FEHBA.

While plaintiff has framed the argument as one of the scope of preemption mandated by 5 U.S.C. § 8902 (m)(1),[4] the court does not find that federal jurisdiction depends on total preemption of every single facet of the relationship between an insured and the carrier. As noted in *Caudill*, "we need not answer the question whether the FEHBA completely preempts state law claims under federal health insurance contracts." 1993 U.S. App. Lexis 10042, at *6.

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[4] Plaintiff argues that the provisions of 5 C.F.R. § 890.107 which leave to the insurer the burden of defending suits based on a denial of benefits are somehow proof that the District Court lacks jurisdiction. We find no merit to this posiiton. The absence of the United States as a party is not particularly relevant to the inquiry of whether a particular suit arises under the laws of the United States. 28 U.S.C. § 1441(b). Health insurance coverage disputes governed by ERISA are cogent examples.

ERISA does not preempt every aspect of state law which might relate to an insurance policy. *See Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. at 44-45. Neither does FEHBA, consonant the its [sic] legislative intent discussed above. However, where the very legal framework by which federal employees receive health insurance is detailed by a federal statute, where there is an express exemption provision mandating uniformity of benefits (§ 8902(m)(1)), where much of the cost of coverage is borne by the federal government, where the party contracting for the coverage is a government agency (OPM), and where there is an allowable administrative appeal of the denial of coverage, one can only be led to the conclusion that a dispute between a federal employee and his carrier is one arising under the laws of the United States. 28 U.S.C. §§ 1331 and 1441(b). To say that private ERISA health insurance disputes are subject to federal jurisdiction while FEHBA disputes are not simply flies in the face of common sense and Supreme Court precedent.

Quite clearly, one of the defenses in this matter will be federal preemption, which ordinarily does not appear on the face of a "well pleaded complaint" and which therefore does not authorize removal from a state to federal court. *Metropolitan Life Ins. Co. v. Taylor,* 481 U.S. at 63; *Louisville & Nashville RR Co. v. Mottley,* 211 U.S. 149, 152 (1908). However, even though a complaint purports to raise only state law issues, where the complaint is "necessarily federal in character by virtue of the clearly manifested intent of Congress . . . [i]t, therefore, 'arise[s] under the . . . laws . . . of the United States,' 28 U.S.C. § 1331, and is removable to the federal court by the defendants, 28 U.S.C. § 1441(b)." 481 U.S. at 67.

Mention should also be made of the decision in *Boyle v. United Technology,* 487 U.S. 500 (1987) where even absent a specific preemption statute the court found that federal common law applied to a claim by the family of a helicopter pilot who died in a crash of a helicopter

alleged to have been defectively constructed pursuant to a military procurement contract. The court found preemption because the dispute involved "uniquely federal interests." 487 U.S. at 504.

Finally, it must be noted that, in a case factually indistinct from the one before us, the Fourth Circuit found that the District Court was correct in assuming jurisdiction over the review of OPM's interpretation of a Blue Cross policy. In *Caudill v. Blue Cross and Blue Shield of North Carolina, supra,* a federal employee seeking high dose chemotherapy and autologous bone marrow transplant support brought suit in state court. Defendants removed to federal court, and plaintiff filed a motion for remand. In denying the plaintiff's motion, the Fourth Circuit relied on *Boyle's* two-part test for determining the applicability of federal common law: (1) the matter must involve a uniquely federal interest; (2) there must be a "significant conflict" between the federal law or policy and the effect of the state law. *Caudill,* 1993 U.S. App. Lexis 10042 at *7-10; *Boyle,* 487 U.S. at 507. Finding both factors satisfied, the Court held that federal common law would govern review of FEHBA claims. We arrive at the same result.

For the reasons set forth above,

IT IS on this 10th day of September, 1993,

ORDERED THAT the plaintiffs' motion to remand the within matter to the Superior Court of New Jersey be, and the same hereby is, DENIED.

/s/ Joseph E. Irenas
JOSEPH E. IRENAS
U.S.D.J.

APPENDIX G

STATUTORY PROVISIONS

Federal Employees Health Benefits Act, 5 U.S.C. §§ 8901-14:

* * * *

§ 8902. Contracting authority

* * * *

(d) Each contract under this chapter shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable.

* * * *

(j) Each contract under this chapter shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Office finds that the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title is entitled thereto under the terms of the contract.

* * * *

(m)(1) The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

* * * *

§ 8907. Information to individuals eligible to enroll

(a) The Office of Personnel Management shall make available to each individual eligible to enroll in a health benefit plan under this chapter [5 USCS §§ 8901 et seq.] such information, in a form acceptable to the Office after consultation with the carrier, as may be necessary to enable the individual to exercise an informed choice among the types of plans described by section 8903 and 8903a of this title.

(b) Each individual enrollee in a health benefits plan shall be issued an appropriate document setting forth or summarizing the—

(1) services or benefits, including maximums, limitations, and exclusions, to which the enrollee or the enrollee and any eligible family members are entitled thereunder;

(2) procedure for obtaining benefits; and

(3) principal provisions of the plan affecting the enrollee and any eligible family members.

* * * *

§ 8909. Employees Health Benefits Fund

(a) There is in the Treasury of the United States an Employee Health Benefits Fund which is administered by the Office of Personnel Management. The contributions of enrollees and the Government described by section 8906 of this title shall be paid into the Fund. The Fund is available—

(1) without fiscal year limitation for all payments to approved health benefit plans; and

(2) to pay expenses for administering this chapter within the limitations that may be specified annually by Congress.

Payments from the Fund to a plan participating in a letter-of-credit arrangement under this chapter shall, in connection with any payment or reimbursement to be made by such plan for a health service or supply, be made, to the maximum extent practicable, on a checks-presented basis (as defined under regulations of the Department of the Treasury).

* * * *

§ 8912. Jurisdiction of courts

The district courts of the United States have original jurisdiction, concurrent with the United States Claims Court [United States Court of Federal Claims], of a civil action or claim against the United States founded on this chapter.

§ 8913. Regulations

(a) The Office of Personnel Management may prescribe regulations necessary to carry out this chapter.

* * * *

Title 28, United States Code, Judiciary & Judicial Procedure:

§ 1441. Actions removable generally

* * * *

(b) any civil action of which the district courts have original jurisdiction founded on a claim or right arising under the Constitution, treaties or laws of the United States shall be removable without regard to the citizenship or residence of the parties. * * *

* * * *

Federal Employees Health Benefits Program, 5 C.F.R. Part 890:

* * * *

§ 890.105 Filing claims for payment or service

(a) *General.* Each health benefits plan adjudicates claims filed under the plan. An enrollee must initially submit all claims to the health benefits plan in which he or she is enrolled. If the plan denies a claim, the enrollee may ask the plan to reconsider the denial. If the plan affirms its denial or fails to respond as required by paragraph (b) of this section, the enrollee may ask OPM to review the claim.

(b) *Timeframes for reconsidering a claim.* (1) The plan must reconsider its initial denial of a claim (or a portion of a claim) when an enrollee submits a written request for reconsideration to the plan within 1 year after the date of the notice to the enrollee that the claim was denied.

* * * *

(3) If a plan either affirms its denial of a claim or fails to respond to an enrollee's written request for reconsideration within 30 days after the date it receives the request or within 30 days after the date it receives additional information requested, the enrollee may write to OPM and request that OPM review the plan's decision. The enrollee must submit the request for OPM review within the timeframes specified in paragraph (d)(1) of this section.

* * * *

(c) *Information required to process requests for reconsideration.*

* * * *

(3) If the plan affirms the initial denial, it must provide written notice to the enrollee. This notice must inform the enrollee of (i) the specific and detailed reasons for the denial; (ii) the enrollee's right

to request a review by OPM; and (iii) the requirement that requests for OPM review must be received within 90 days after the date of the plan's notice of denial.

(d) *OPM Review.* (1) OPM must accept a request for review that is received (i) within 90 days after the date of the plan's notice to the enrollee that the denial was affirmed; or (ii) if the plan fails to respond to the enrollee as provided in paragraph (b)(2) of this section, within 120 days after the date of the enrollee's timely request for reconsideration by the plan or the date the enrollee is notified that the plan is requesting additional information. OPM may extend the time limit for an enrollee's request for OPM review when the enrollee shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by a plan, OPM may (i) request that the enrollee submit additional information; (ii) obtain an advisory opinion from an independent physician; (iii) obtain any other information as may in its judgment be required to make a determination; or (iv) make its decision based solely on the information the enrollee provided initially with his or her request for review.

(3) When OPM requests information from a plan, the plan must release the information within 30 days after the date of OPM's written request unless a different timeframe is specified by OPM in its request. Any evidence submitted by the enrollee or by the plan for review of the denied claim will be held as privileged information and will be reviewed only by persons having official need to see it.

(4) Within 30 days after receipt of the necessary evidence, OPM will give a written notice of its deci-

sion to the enrollee and the plan. If OPM does not receive requested evidence within 15 days after the date specified in paragraph (d)(3) of this section, OPM may make its decision based solely on information available to it at that time and give a written notice of its decision to the enrollee and to the plan.

(5) If OPM does not request additional evidence, OPM will give a written notice of its decision to the enrollee and to the plan within 30 days after receipt of the enrollee's request for review.

* * * *

§ 890.107 Legal actions

An action to compel enrollment of an employee or annuitant not excluded by § 890.102(c) should be brought against the employing office. An action to recover on a claim for health benefits should be brought against the carrier of the health benefits plan. An action to review the legality of OPM's regulations under this part or of a decision made by OPM should be brought against the Office of Personnel Management, Washington, DC 20415. However, an enrollee's dispute of an OPM decision solely because it concurs in a health plan carrier's denial of a claim is not a challenge to the legality of OPM's decision. Therefore, any subsequent litigation to recover on the claim should be brought against the carrier, not against OPM.

* * * *

APPENDIX H

1993 FEHBA Contract Between
U.S. Office of Personnel Management
and the
National Postal Mail Handlers Union

PART I— GENERAL PROVISIONS

SECTION 1.1 DEFINITIONS OF FEHB TERMS (JAN. 1991)

For purposes of this contract, the following definitions apply:

FEHBP:

Federal Employees Health Benefits Program.

Enrollee:

The Federal employee, annuitant, former spouse, temporarily-covered former Federal employee or dependent, enrolled under this contract.

Member:

The Enrollee and/or an eligible dependent for benefit purposes.

Act:

The Federal Employees Health Benefits Act, as amended; chapter 89, of title 5, United States Code.

Regulations:

(1) The Federal Employees Health Benefits Regulations; Part 890, Title 5, Code of Federal Regulations, and (2) Chapters 1 and 16 of Title 48, Code of Federal Regulations.

Benefits:

Covered services or payment for covered services set forth in the brochure, to which Members are entitled to the extent provided by this contract.

Carrier:

As defined by chapter 89 of title 5, United States Code, and may be used interchangeably with the term Contractor.

* * * *

SECTION 1.4 INCORPORATION OF LAWS AND REGULATIONS (JAN. 1991)

(a) The applicable provisions of (1) chapter 89 of title 5, United States Code; (2) OPM's regulations as contained in Part 890 of Title 5, Code of Federal Regulations; and (3) Chapters 1 and 16 of Title 48, Code of Federal Regulations constitute a part of this contract as if fully set forth herein, and the other provisions of this contract shall be construed so as to comply therewith.

* * * *

SECTION 2.2 BENEFITS PROVIDED (JAN. 1991)

(a) The Carrier shall provide the benefits as described in the brochure or any addendum issued to the brochure for the time period specified in the brochure or any addendum. Such brochure and any addendum are attached as *Appendix A* and made a part of this contract.

* * * *

(b) The Carrier shall not provide benefits for services or supplies which are not medically necessary or are expressly excluded by the terms of the contract or the Appendix A benefits brochure.

* * * *

(d) The Carrier agrees to pay for or provide a health service or supply in an individual case if OPM finds that the Member is entitled thereto under the terms of the contract.

SECTION 2.3 PAYMENT OF BENEFITS AND PROVISION OF SERVICES AND SUPPLIES (JAN. 1991)

* * * *

(h) No lawsuit may be brought by or on behalf of a Member to recover on a claim for Plan benefits until the Member or, in the case of an assigned claim, the Member's provider exhausts this OPM review procedure which is established at section 890.105, Title 5, Code of Federal Regulations (CFR). If OPM upholds the Carrier decision on the Member's claim, and the Member then decides to bring a lawsuit based on the claim denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, Title 5, CFR, such a lawsuit must be brought against the Carrier.

(i) Federal law exclusively governs all Member claims for relief in a lawsuit that relate to Plan benefits or coverage provided to Members or payments with respect to those benefits. As provided under this agreement between the Carrier and the Office of Personnel Management, judicial action on such claims for relief is limited to a review of OPM's final decision to determine if it is arbitrary or capricious under the terms of the brochure statement of benefits. Damages recoverable in such lawsuits are limited to the amount of Plan contract benefits in dispute, plus simple prejudgment interest (at the rate prescribed by section 1961(a) of title 28, U.S. Code) and court costs.

* * * *